



**Department of Veterans Affairs
Office of Inspector General**

**EVALUATION OF VHA SOLE-SOURCE
CONTRACTS WITH MEDICAL
SCHOOLS AND OTHER AFFILIATED
INSTITUTIONS**

**To Report Suspected Wrongdoing in VA Programs and Operations
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Contents

	Page
Executive Summary	i
Introduction	1
Purpose.....	1
Background.....	1
Scope and Methodology	3
Results and Conclusions	5
Issue 1: General Contracting Issues.....	5
Issue 2: Contract Pricing.....	19
Issue 3: Conflict of Interest and Other Legal Issues.....	46
Appendix A - Pre-Award Reviews for Sole-Source Contracts with Affiliates	61
Appendix B - Post-Award Reviews for Sole-Source Contracts with Affiliates.....	69
Appendix C - Director’s Comments to Office of Inspector General’s Report.....	70
Appendix D - OIG Contact and Staff Acknowledgments	84
Appendix E - Report Distribution.....	85

Executive Summary

Introduction

Since the beginning of Fiscal Year (FY) 2000, the Department of Veterans Affairs (VA), Office of Inspector General (OIG) has been conducting pre-award reviews of proposals for contracts to be awarded on a sole-source basis to VA affiliates. These reviews, combined with post-award reviews, Combined Assessment Program (CAP) reviews, and interactions with VA personnel, have identified numerous issues that need to be addressed. The purpose of this report is to advise you of our collective findings and make recommendations for improvement in the procurement of health care resources in order to ensure quality health care is provided to veteran patients and to protect the interests of the Government.

Results

In November 1999, Veterans Health Administration (VHA) issued VHA Directive 99-056, requiring a pre-award review by the OIG Contract Review and Evaluation Division of all contract proposals valued at more than \$500,000, inclusive of option years, that were to be awarded on a sole-source basis to affiliated institutions pursuant to the provisions of 38 U.S.C. §8153. Since FY 2000, 92 proposals have been submitted for pre-award review, and 3 sole-source contracts with affiliates were submitted for post-award review. Of the 92 pre-award requests, 9 were canceled by the requesting facility. As of October 15, 2004, we completed 72 of the remaining 83 proposals submitted for pre-award review and recommended \$24.9 million in better use of funds (BUOF), which represented approximately 21 percent of the total value of the proposed prices. Of the 72 completed reviews, 54 contracts were negotiated and awarded as of October 15, 2004. In the 54 reviews, we recommended \$16.4 million in BUOF, of which \$10.2 million (62 percent) was sustained during contract negotiations. On a scale of 1 to 5, with 5 being the highest, VA responses to 21 customer satisfaction surveys assessing our pre-award reviews during FY 2000 to 2004 resulted in an average score of 4.5.

In addition to identifying BUOF, our reviews included reviewing other aspects of the procurement process such as planning, the statement of work and other terms and conditions in the solicitation, and contract administration. These aspects of the procurement process are important because, in addition to affecting the price reasonableness determination, they impact on whether the contract itself is in the best interest of the Government.

Our results and recommendations are presented in three sections: (1) General Contracting Issues, (2) Contract Pricing, and (3) Conflict of Interest and Other Legal Issues. With respect to general contracting issues, we concluded that acquisition planning and

justification for contracting out for services was inadequate and that some contracts were awarded to meet the needs of the affiliate, not VA.

With respect to contract pricing, the sole-source solicitations we reviewed were divided into two general categories: (a) services that were provided at the affiliate and (b) services provided at VA. For services provided at VA, pricing was either Full Time Equivalent (FTE) based or procedure based. When the services were provided at the affiliate, all the proposals were procedure based. We concluded that VA was overpaying the affiliates for services provided under both of these pricing structures.

The legal issues discussed in this report include violations of conflict of interest laws; the use of personal services contracts; contract requirements that were inherently governmental functions; and the Government's liability for acts or omissions of contract employees under the Federal Tort Claims Act, even though VA was paying for their medical malpractice insurance under these contracts.

Issue 1: General Contracting Issues

- We found a lack of acquisition planning, as required by Federal and VA acquisition regulations. For example, contracting officers are frequently not involved in acquisition planning and are not given sufficient time to plan. Also, VHA facilities are using sole-source contracts with affiliates to acquire services without sufficient evidence that the services could not be acquired through direct hiring or that the sole-source contracts were in the best interest of the Government. We also found a lack of documentation to support the level of services being requested.
- We identified contracting processes that interfered with the contracting officers' ability to fulfill their responsibilities. For example, records show that some solicitations were written after VHA negotiated terms, conditions, and pricing with the affiliates. In some cases, the affiliates even dictated the terms and conditions, including the number and type of personnel needed to provide the services, and these terms were accepted by VHA.
- We identified solicitations that did not include terms and conditions that would protect the interests of the Government. Examples include:
 - No procedures by VHA to monitor contract physician presence and level of performance to ensure that the level of services VA pays for under the contract was actually provided.
 - No requirement that contract physicians providing on-call and emergency call-back services will be dedicated to VA or how call-back hours will be applied to the hours paid for under the contracts.

- Solicitations either did not require penalties for non-compliance with the terms and conditions of the contract or did not adequately compensate VA for any losses incurred as a result of non-compliance.
- Statements of work prescribe that contract employees will have clinical, administrative, and in some cases, research responsibilities. However, the amount of time expected to be devoted to each of these responsibilities is not delineated in the solicitation and is left to the affiliate to decide. The amount of time to be devoted to non-clinical duties impacts on the number of FTE needed under the contract to provide patient care.
- When services are provided at the affiliate, solicitations do not adequately define the process for obtaining approval for treatment in excess of contract terms.
- Given access to electronic solicitations, affiliates have added contract clauses addressing termination rights and other requirements that may not be in the best interest of the Government, and that were not brought to the attention of VA.
- VHA is not complying with the requirement to refer proposals to the OIG for pre-award review. For example, in FY 2003 the VHA Resource Sharing Office reported that 99 contracts valued at \$500,000, or more, were awarded. Only 3 of the 99 were referred for a pre-award review. Applying the 21 percent BUOF to the universe of contracts awarded in FY 2003 would have resulted in potential cost savings of \$41 million. Applying the 62 percent average savings sustained during contract negotiations, estimated cost savings would have been \$25.4 million for FY 2003.

Issue 2: Contract Pricing

- FTE Based Contracts for Services Provided at VA: We have identified the following issues that can result in VA overpaying for services under FTE based contracts.
 - VHA proposes using the national salary database maintained by the American Association of Medical Colleges (AAMC) as the basis for determining fair and reasonable pricing for these contracts. Based on our review of the database, the methodology used to collect the data, and discussions with personnel at AAMC, we believe the database is not a reliable source to establish fair and reasonable prices. One reason is the significant variation between the reported salaries at each percentile level. For example, in Thoracic/Cardiovascular surgery, the published AAMC rates for the Associate Professor level are \$270,000, \$340,000, and \$422,000 respectively. If the price is set at the 50th or 75th percentile, as proposed by VHA, and the contract physician is paid at the 25th percentile, or less, VA would be paying between \$70,000 and \$152,000, or more, than the affiliate

would pay the physician. VHA also proposes that a pre-award review would not be required until the FTE based contract exceeded the 75th percentile of the AAMC rates, which, if adopted, would essentially eliminate pre-award reviews.

- Because contracts awarded under §8153 authority are commercial item contracts, the Federal Acquisition Regulation (FAR) requires them to be firm-fixed price. This means that all costs the affiliate may potentially incur in providing services under the contract are negotiated up front and eventually paid for, even if the expenses are never incurred. For example, proposed prices have included annual incentive pay as high as \$200,000 per physician, with no assurance that any of the physicians who provide services under the contract will actually receive the incentive pay, or that the basis for the incentive pay will be related to performance at VA. We believe that §7409 provides VA with greater flexibility in choosing the appropriate contract type, such as a cost-reimbursement contract under which VA would reimburse an affiliate for actual costs.
- Solicitations do not require the identification of key personnel who will be providing services under the contract or the level of effort each will provide. In addition to quality of care concerns, we have found that this often results in VA paying excessive prices for the services provided. In one proposal, the affiliate proposed an annual cost of \$418,000 per FTE for three interventional radiologists. This price was based on an average of the salaries of the seven interventional radiologists on staff at the affiliate, which ranged from \$293,000 to \$441,000. Our review of the three radiologists who actually provided services under the contract determined that their annual salaries ranged from \$386,000 to \$387,000. If VHA accepted the proposed prices, VA would have paid the affiliate approximately \$96,000 more per year than the affiliate paid the physicians. This disparity is compounded when the physician with the lowest compensation package performs most of the services.
- Proposals usually include charges for overhead expenses which vary significantly from facility to facility. Our reviews have found a wide variation in the types of expenses included in overhead calculations, not all of which relate to the costs incurred to provide services to VA under the contracts. We also found that VA has not provided specific guidance regarding what overhead costs can or should be allowed in making price reasonableness determinations.
- Proposals included payment for on-call duty as an additional expense for VA to pay, even though the contract physicians were not paid additional compensation for on-call time by the affiliate because it was already included in their salary and benefits packages. Including additional payments for on-call time results in VA paying more than fair and reasonable prices for the services provided.

- We also identified a situation where VA was overcharged because a part-time VHA physician was serving virtually all of his on-call duty at VA as a contract employee of the affiliate. The physician did not provide on-call services as part of his VA duties. We concluded that the absence of a specific VHA policy delineating on-call requirements for part-time physicians can result in VA paying unnecessary costs for the coverage under these contracts.
- Although §8153 does not address the issue of whether VA may pay a profit under these sole-source contracts, VHA Directive 99-056 indicates that the affiliate can earn a profit. Even though we have reviewed proposals resulting in a profit for the affiliate, we have not seen profit identified as a separate line item as required by the FAR. Also, given the fact that the basis for allowing sole-source agreements with the affiliate is to maintain the mutually beneficial relationship involving the training of medical students and residents, we question whether the affiliate should be making a profit off the VA. We believe the BUOF identified in our pre-award reviews is a conservative example of the amount of profit affiliates can get paid from these contracts.
- Procedure Based Contracts for Services Provided at VA: The following examples illustrate how VA can overpay for services provided at VA medical facilities under procedure based contracts using Medicare Part B rates.
 - Medicare Part B rates include an overhead component to compensate the provider for office expenses such as rent, utilities, support staff, supplies, etc. This component represents on average 30 percent of the Medicare Part B rate. When services are provided at VA, the Government, not the provider, incurs these costs. The failure to deduct this component from the proposed prices results in VA paying these expenses twice.
 - Medicare Part B regulations, 42 CFR 415.17 et seq., generally require that the attending physician either perform the procedure or be physically present during the procedure to qualify for payment. None of the procedure based proposals we have reviewed contain these or similar requirements. As a result, VA can end up paying more than fair and reasonable costs under the contract because the affiliate is paid for the services whether or not the attending physician is present during the procedure or examination.
 - We have also reviewed proposals in which the affiliate proposed pricing that is not on a strict per procedure basis, as are Medicare Part B rates. Rather, the affiliate estimates the number of various types of procedures that may be performed during the year and uses these estimates to calculate and propose daily, weekly, or monthly rates. Overpayment occurs when the daily, weekly, or monthly rates exceed the Medicare Part B rates for the actual procedures performed; when the

estimated number or type of procedures exceed actual workload; and when VA facilities do not monitor workload to exclude interactions covered by global procedure rates.

- Some affiliates have proposed a pricing structure that requires procedure based payments for in-patient care and payments on an FTE basis for outpatient visits, including follow-up care. Medicare Part B payments for many surgical procedures are global in nature in that they include pre-operative care and follow-up for specific periods of time, e.g., 90 days. Paying the full rate for the attending physician's services for the procedure and then paying the physician a salary to see the patient for follow-up during the global time period, results in the Government paying twice for the same services.
- VHA facilities do not have adequate internal control systems in place to monitor the services provided on a procedure basis to ensure that VA is not overcharged.
- Contrary to our conclusion that Medicare Part B rates can result in VA overpaying for services, VHA has proposed allowing VA facilities to negotiate prices up to 150 percent of the established Medicare rates. VHA also proposes that a pre-award review would not be required until the contract exceeds 150 percent of the Medicare rate, which, if adopted, would essentially eliminate pre-award reviews.
- Procedure Based Contracts for Services Provided at Affiliates: Affiliates are reluctant to limit payment to Medicare rates when the services are provided at their facilities. Issues raised in our pre-award reviews that can result in VA overpaying for services provided at affiliates include:
 - Solicitations for in-patient surgical services to be provided at an affiliate require that the patients be transferred back to VA for care after the procedures but prior to their discharge. As a result, the affiliates have developed pricing proposals that would maximize their revenue under this requirement. Our reviews have shown that this methodology can result in VA overpaying for the care provided. For example, the Medicare Part A rate for a heart transplant at an affiliate is \$138,906, which is based on an average length of stay of 40 days. In response to the solicitation's requirements, the affiliate proposed pricing for hospital costs that included a flat rate for an initial 3-day length of stay and a per diem rate for each additional day. Our review showed that under the affiliate's proposal VA would have paid \$224,600 if the patient remained at the affiliate for 40 days, which is \$85,694 more than the Government would have paid under Medicare Part A for the same care and treatment.
 - In addition to paying for the costs of hospitalization when patients are treated at the affiliate, VA also pays for physician services as part of the Medicare Part

B rate. When patients are transferred back to VA and/or receive follow-up care at VA, either VA physicians provide the care, or VA pays for the care through another contract. Either way, if the Medicare Part B rates paid to the affiliate are not adjusted to reflect the patient transfer, VA pays twice for the care because the Medicare Part B payments are global.

- Pharmaceutical costs can account for as much as 20 percent of the total contract price. Because VA can procure drugs at a lesser cost, excluding pharmaceutical costs from the rate calculation and reimbursing the affiliate “in-kind” for many of the drugs needed for the medical procedures performed under the contract would produce significant cost savings for VA.

Issue 3: Conflict of Interest and Other Legal Issues

- We identified situations where VA physicians, who have a financial interest in the affiliate and/or the affiliate’s practice group, are involved in the contracting process in violation of Federal ethics laws and regulations. The most frequent violations that we identified are when VA physicians, who are also employed by the affiliate or the affiliate’s practice group, submit a request for or approve a request for a contract with the affiliate. In some cases, the physicians requesting or approving the contract are part-time VA employees who, in addition to their VA duties, will be providing services at VA under the contract. These actions violate 18 U.S.C. §208, which prohibits employees of the Executive Branch from participating personally and substantially as a Government officer or employee in any matter in which he or she has a financial interest. We worked closely with the VA Office of General Counsel (OGC) in reviewing these matters as they arose.
- We identified solicitations for services that were outside the scope of §8153 authority. Examples include purchasing the services of residents or other physicians in training, services needed to conduct administrative reviews to establish a statement of work for a future or follow-on contract with an affiliate, services that can be performed more cost-effectively by VA employees, services for positions currently encumbered by VA personnel, and consulting services.
- FAR 37.104 prohibits agencies from entering into personal services contracts unless specifically authorized by statute. Because §8153 does not specifically authorize VA to enter into personal services contracts, VHA and OGC have determined that these contracts cannot be for personal services. However, we have concluded that many of these contracts are personal services contracts. As an example, contract anesthesiologists were required to provide supervision to certified registered nurse anesthetists, anesthesiology residents and technicians, all of whom are VA employees. While we recognize the need for proper supervision of these employees, supervision of Government employees is an inherently governmental function and, thus, cannot be

provided under contract unless specifically authorized by statute. However, if personal services contracts are authorized, they would allow VA to properly supervise all employees providing veterans care in VA hospitals, including contract employees.

- Under non-personal services contracts, contractors are required to provide medical liability insurance coverage for all contract employees. The cost for this insurance is included in the amount paid by VA. Based on our reviews of FTE based contracts, the medical malpractice component averaged 3.3 percent of the contract costs. For procedure based contracts, approximately 7 percent of the Medicare Part B payment relates to the medical malpractice component. The problem, however, is that in most cases there is no clear distinction between the work done by contract employees and VA employees, particularly when part-time VA employees also provide part-time services at VA as contract employees. Lacking this distinction, VA may be liable for acts or omissions that result in injury to a patient, regardless of who was at fault. In response to our inquiry, OGC told us that they were not aware of any cases filed against a contractor instead of VA, but that it would be unlikely that VA would not be a party to an action when the care was provided at VA. We have concluded that VA should take the necessary actions to make contracts for services provided at VA personal services contracts. Personal services contracts would result in a cost savings to VA because it would no longer have to pay for medical liability coverage from which the Government derives no benefit.

Comments

The Acting Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. We will continue to follow-up on all planned actions until all of the issues have been resolved.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Purpose

Since the beginning of FY 2000, the OIG has been conducting pre-award reviews of proposals for contracts to be awarded on a sole-source basis to VA affiliates pursuant to the provisions of 38 U.S.C. §8153. As a result of our pre- and post-award reviews and interactions with VA personnel, we have identified a number of issues involving these contracts and areas that need improvement. The purpose of this report is to advise VA of our collective findings and make recommendations for improvement to protect the interests of veteran patients and the Government.

Background

One of VA's statutory missions is to conduct an education and training program for health professions. Each year over 76,000 medical and associated health students, residents, and fellows receive some or all of their clinical training in VA facilities through affiliations. VA is affiliated with over 1,200 educational institutions, including 107 medical schools. Under its sharing authority in 38 U.S.C. §8151–8153, VHA may enter into contracts for the purchase of health care resources with any health care provider. This includes VHA entering into non-competitive sharing agreements (sole-source contracts) with an affiliated academic institution, a teaching hospital, or an individual physician or practice group associated with the medical school or other affiliated institution.

In November 1999, VHA issued Directive 99-056, requiring a pre-award review by the OIG Contract Review and Evaluation Division of all contract proposals valued at more than \$500,000 that were to be awarded on a sole-source basis to an affiliated institution pursuant to the provisions of 38 U.S.C. §8153. Since FY 2000, 92¹ proposals have been submitted for pre-award review. Of those 92 proposals, nine were canceled by the requesting facility. As of October 15, 2004, we completed 72 pre-award reviews and recommended \$24.9 million in BUOF, which represents approximately 21 percent of the total value of the proposed prices. Of the 72 completed reviews, 54 contracts were negotiated and awarded as of October 15, 2004. In the 54 reviews, we recommended \$16.4 million in BUOF, of which \$10.2 million (62 percent) was sustained during contract negotiations. On a scale of 1 to 5, with 5 being the highest, VA responses to 21 customer satisfaction surveys assessing our pre-award reviews during FY 2000 to 2004 resulted in an average score of 4.5

Two of the pre-award reviews resulted in non-award recommendations, because the affiliate refused to provide the data needed to determine whether the proposed prices

¹ These 92 requests include those for which we have issued a report (72), those that have been canceled (9), and those currently active (11).

were fair and reasonable. One contract valued at \$1.9 million was not awarded. The other contract, valued at \$1 million, was awarded. The facility cited the need to maintain services as the basis for awarding the contract.

In addition to the 92 pre-award reviews requested pursuant to VHA Directive 99-056, the OIG Contract Review and Evaluation Division conducted 3 post-award reviews of sole-source contracts with affiliates. One review was conducted because there was a dispute between VA and the affiliate regarding payment under the contract. The other review was initiated by the OIG as a follow-up to a Combined Assessment Program (CAP) review. A third post-award review was requested but subsequently canceled by the contracting officer before the review was completed and a report issued. See Appendix A for a listing of the pre-award reviews. See Appendix B for a listing of the post-award reviews.

We discussed issues relating to these contracts in meetings with VHA program officials, representatives from the Office of Acquisition and Materiel Management (OA&MM), and OGC. We also participated in a working group established by VHA's Resource Sharing Office to establish policy and direction for VA medical centers. For the past 2 years, we provided training on the issues presented in this report to VHA acquisition personnel who attended forums sponsored by OA&MM. We also were invited to present and discuss these issues with management personnel in Veterans Integrated System Network 6. As a result of our pre-award and post-award reviews and our training efforts, we have had extensive discussions with VHA acquisition personnel who have contacted us seeking advice and guidance on these issues.

The sole-source solicitations we reviewed were divided into two general categories: services that were to be provided at the VA and services that were to be provided at the affiliate. For services to be provided at VA, pricing was either FTE based or procedure based. When services were to be provided at the affiliate, the pricing structure in all the proposals and contracts was procedure based.

Under FTE based contracts, prices are based on the salaries, benefits, and other costs associated with providing a specific number of individuals to provide services at VA. Other costs associated with FTE based contracts included in contract proposals were overhead, administrative costs, education allowances, incentive fees or awards, parking allowances, on-call coverage, etc.

When services are performed at VA and payment is procedure based, pricing structures vary from prices negotiated and paid for each procedure or examination to using an anticipated number and type of procedures to establish a daily, monthly, or annual price. Procedure based contracts use Medicare Part B (physician services) rates as the benchmark to establish or evaluate the reasonableness of contract pricing.

Medicare Part A (hospital costs) and Medicare Part B are used as the benchmark for contract pricing when services are to be provided at the affiliate. Pricing for the hospital costs is usually based on a specified expected length of stay with a negotiated daily rate for each additional day.

Scope and Methodology

This report is a compilation of the findings related to various proposals submitted for pre-award reviews, contracts submitted for post-award reviews, contract files reviewed during CAP reviews and in response to allegations received through the OIG Hotline, and our interactions with contracting and other personnel in VHA and at VA affiliates.

The primary purpose of our pre-award reviews is to determine the reasonableness of the proposed prices. Pre-award reviews of health care resource proposals include reviewing the solicitation files, evaluating the terms and conditions of VA's solicitations, identifying the health care professionals who will be providing services under the contracts to evaluate pricing and to determine if there are any real or potential conflict of interest issues, reviewing proposed prices to determine whether they are fair and reasonable in accordance with the provisions of the Federal Acquisition Regulations (FAR), Veterans Affairs Acquisition Regulations (VAAR), Center for Medicare and Medicaid Services (CMS) guidelines, and VA policy.

More specifically, for proposals that are FTE based, we obtain and review all information that supports the proposed prices. This information includes the identification of personnel who will provide services under the contract; contractual agreements between these individuals and the affiliate; documentation showing the actual salary and benefits paid the individuals; an explanation as to the number of hours, duties, and responsibilities each provider is expected to perform to earn the salaries and benefits; and documentation showing the portion of the work expected to be performed that relates directly to the contract with VA. In addition, we requested documentation from the affiliate to support prices that include overhead, administrative, and other costs not directly related to salaries and benefits.

For pricing proposals that are procedure based, Medicare rates are used as the benchmark to determine price reasonableness. To accurately review procedure based proposals, we consulted with CMS in the Department of Health and Human Services. We also reviewed CMS publications, including regulations. The purpose was to gain a better understanding of how Medicare rates are established, how medical facilities and providers are paid, and the relationship between the rates and the services being procured by VA.

Post-award reviews of contracts for health care resources include determining the level of services that were rendered under contract, evaluating whether payment for the services

was reasonable and proper and, when pricing was based on Medicare rates, whether the services would have been eligible for payment under CMS regulation.

We also reviewed various aspects of sole-source contracts with affiliates during our CAP reviews. Issues addressed in our reports include whether adequate price analyses were conducted, price negotiations memoranda were prepared and maintained, proposals over the \$500,000 threshold were referred for pre-award review, solicitations contained provisions that protect the interests of the Government, VA officials complied with conflict of interest laws and regulations, and contracts were appropriately administered.

Results and Conclusions

Issue 1: General Contracting Issues

Findings

Our reviews and the business reviews conducted by OA&MM have often shown that the contracting process for sole-source contracts awarded under the authority of 38 U.S.C. §8153 does not comply with the FAR, VAAR, VHA policy, or prudent business practices. Problems include the absence of acquisition planning, negotiation of contracts with the affiliate before issuing a solicitation, and inclusion of terms and conditions in the solicitation that are inconsistent or do not protect the Government's interests. In addition, VA has accepted proposals that are incomplete or not responsive to the solicitations.

Lack of Acquisition Planning

Contracting officers are frequently not involved in acquisition planning or are not given sufficient time to plan the acquisition as required in FAR Part 7, and VAAR 873.105, Simplified Acquisition Procedures for Health-Care Resources, Acquisition Planning, which states:

- Acquisition planning is an indispensable component of the total acquisition process.
- For the acquisition of health-care resources consisting of commercial services or the use of medical equipment and space, where the acquisition is expected to exceed the simplified acquisition threshold, an acquisition team must be assembled. The team shall be tailored by the contracting officer for each particular acquisition expected to exceed the simplified acquisition threshold. As a minimum, the team must include the contracting officer and a representative of the requesting service.
- In lieu of the requirements of FAR Part 7 addressing documentation of the acquisition plan, the contracting officer may conduct an acquisition strategy meeting with offices cognizant to seek approval for the proposed acquisition approach. If a meeting is conducted, briefing materials shall be presented to address the acquisition plan topics and structure in FAR 7.105. Formal written minutes shall be prepared to summarize decisions, actions, and conclusions, and be included in the contract file along with a copy of the briefing materials.

None of the 92 solicitation files that we reviewed contained documentation showing that an acquisition planning process, as described in VAAR 873.105, actually took place.

Rather, the documentation in the files, or provided in response to our request, showed that the acquisitions were based on requests from the affected clinical services, usually signed by the Service Chiefs, and approved by the Chiefs of Staff and/or other VA management officials. In five cases, the Service Chiefs who requested the sole-source contract with the affiliate were also employed by the affiliates, and in some instances were also expected to provide services under the contracts.²

The first step in the acquisition planning process is to determine whether the services can be obtained through direct hire or whether it is necessary or more cost effective to hire the resources through a contract. VA medical centers were unable to provide us with documentation showing reasonable efforts to hire the services directly or that alternative sources were considered. In at least two reviews, medical center personnel advised us that they had placed an ad in a medical journal.

In response to inquiries relating to immigration visas for two physicians expected to provide services at VA as both contract and VA employees, we received documentation from the medical center relating to the recruitment for the two positions. The records contained evidence that the advertisements were placed in the *New England Journal of Medicine*. Both announcements stated that the position was a full-time position at the VA medical center and the point of contact listed was the VA Office of Human Resources. However, the announcements also stated that the applicant must qualify for a faculty appointment at the university and that "...the position may be shared with other university hospitals." Contrary to the statement in the announcements that the positions were full-time VA, the positions were actually part-time VA and part-time affiliate. Documentation in one file indicated that the physicians who were selected would be 5/8 VA and that the University would also pay the employee a salary, which VA actually paid to the affiliate under a §8153 contract. There is no indication in either file that the selected applicants, or any other applicants, refused to work for the VA offered salary.

We reviewed medical journals and websites that advertised physician positions throughout the United States. We did not find any announcements by VA medical centers that we knew had contracts with their affiliates looking to hire directly. We did, however, find announcements showing that the position at VA was going to be filled through the University. Some examples include:

- An announcement placed by the affiliate begins with: "The Veterans Affairs Medical Center and the [affiliate] Departments of Radiology are seeking a full-time radiologist for the Chief of the Cardiothoracic Section of Radiology at the VA Medical Center." The announcement lists the information that must be submitted for consideration and instructs applicants to send the information to the

² See 18 U.S.C. § 208. Findings relating to real and potential violations of Federal conflict of interest laws and regulations are discussed in detail in Issue 3.

Chair of the Search Committee who is an employee of the affiliate, not VA.³ Clearly, the affiliate is recruiting for staff the affiliate intends to hire to work at VA.

- Another announcement, placed by VA, for a neurologist states that the position is full-time for VA. Although the announcement states that the responsibilities will be performed at the VA, it also states that the individual will be hired as a 5/8 VA employee and 3/8 employee at the University.

Although the position is advertised as a full-time VA position, applicants are not offered the opportunity to accept or reject the salaries and incentives offered by VA, because it is clear from the outset that that the position is not really a full-time VA position. Rather, the selectee will be a part-time VA employee and a part-time affiliate employee working at VA.

There was also no evidence to show why a sole-source contract with the affiliate was in the best interests of the Government, or that alternative sources were considered, particularly when the services to be provided did not include resident training. The lack of planning was also evident in the fact that once a contract was awarded, medical centers made little or no effort to hire staff directly before the contract year, or option years, expired.

Other findings that show lack of planning include:

- Requests for proposals that are dated less than 60 days prior to the “desired” start date.
- In cases where the medical center admits that they can hire directly, there is no documentation showing why a sole-source contract with the affiliate is in the best interests of the Government.
- Requests include a general requirement such as a number of FTE required for the particular specialty but there is no support, such as workload analysis, for the requirement.

As an example, we recently reviewed a proposal for a 5-year contract for the services of anesthesiologists, certified registered nurse anesthetists (CRNA), anesthesia technicians, a nurse practitioner for pain management, and a physician assistant to perform pre-operative evaluations and post-operative visits. The proposal was for a follow-on to a contract for the same services with the addition of the physician assistant position and an

³ This was one of two announcements we found for positions at the same VA medical center. The affiliate, not VA, was the recruiter under both announcements.

increase in the number of CRNA.⁴ In response to our inquiry as to whether the VA Medical Center had attempted to recruit for the positions, the Chief of Surgery responded:

“We hired our own CRNA until the anesthesia contract was initiated. At the time of contract initiation we were having great concerns about trying to recruit in the face of increasing community competition. We have not attempted to recruit since the initiation of the contract. We have not attempted to recruit the NP [nurse practitioner], PA [physician assistant] or technician as the contract was already in place.”

Documentation in the file shows that two of the individuals hired under the contract were VA employees prior to the initiation of the contract. We compared the salaries that VA could have offered the CRNA to the salaries being paid under the contract and concluded that there was not a significant disparity. VA’s base salary range was \$85,563 - \$113,798 compared to \$96,966 - \$116,250 for the affiliate. In addition, we were told that VA had authority to offer recruitment bonuses and elevated hiring pay based on experience to further compete with the private sector.

Another example involves a contract with an affiliate for surgical services. The contract was for 1 year with 2 option years. Although the medical center complied with the provisions of VHA Directive 99-056 by submitting the solicitation to VA Central Office for legal/technical review, the medical center unconditionally awarded the contract before the review was completed. The legal/technical review approved the solicitation, but only if it was changed from a definite quantity contract to an indefinite delivery, indefinite quantity (IDIQ) contract. An IDIQ contract was preferable because the proposed costs were based on an estimated number and types of procedures expected to be provided. Under a definite quantity contract, VA would be paying for services whether they were provided or not. Under an IDIQ contract, VA would only pay for those services actually rendered. When the affiliate rejected the proposed change, the medical center had no alternative but to continue the first year of the contract. Although the contract contained a cancellation clause, cancellation was not a viable option because the medical center had not identified a reasonable alternative, and the services were needed. Our review showed that the medical center made no effort during the first year of the contract to prepare and issue a new solicitation for the IDIQ contract that the legal/technical review required.

⁴ The request for a sole-source contract with the affiliate for these services was made by the Chief of Surgery who has a financial interest, as defined by 18 U.S.C. § 208, in the affiliate and approved by the Chief of Staff who also has a financial interest in the affiliate.

Contracting Officers Cannot Fulfill Their Responsibilities

The contracting process appears to deny the VA contracting officers the opportunity to fulfill their responsibilities as specified in FAR 1.602, which states:

- Contracting officers with the proper level of authority are the only Government officials authorized to bind the Government in contract.
- No contract shall be entered into unless the contracting officer ensures that all requirements of law, executive orders, regulations, and all other applicable procedures, including clearances and approvals, have been met.
- Contracting officers are responsible for ensuring performance of all necessary actions for effective contracting, ensuring compliance with the terms of the contract, and safeguarding the interests of the United States in its contractual relationships.

We identified cases in which the decision to enter into a contract, the negotiation of requirements, statements of work and other terms and conditions, and/or contract pricing were negotiated between the VA user service and the affiliate prior to the involvement of the contracting officer. In each case, the evidence demonstrated that the solicitation was developed to meet the needs of the affiliate, not necessarily VA. We have reviewed solicitations in which:

- The solicitation appears to have been developed to meet a financial need of the affiliate rather than the needs of VA.
- There was no justification to support the need for a contract. We found this to be common with follow-on contracts. Once a contract is awarded, it becomes the common practice not to make an effort to obtain the services directly.
- The contracting officer was not provided key information needed to prepare a solicitation, such as a comprehensive statement of work.
- The offer submitted by the affiliate did not address the requirements established in the solicitation. Rather, the affiliate determined the medical center's requirements.

The following examples are aspects of solicitations and/or proposals that we have determined were developed to benefit the needs of the affiliate, not VA.

1. A solicitation file contained a letter from the affiliate dated September 4. The letter was a funding request for supplemental support for a project titled "Medical Services Anesthesia," in the amount of \$1,036,585, for a 1-year period beginning October 1 for the

services of 4.375 FTE. The affiliate's proposal only addressed the amount to be paid by VA; it did not contain any terms or conditions, duties or responsibilities, scope of work, etc. The VA solicitation did contain such clauses; but, it was not issued until November 19, more than 2 months after the affiliate submitted its proposal for funding. In conducting the pre-award review, we found that the solicitation issued by VA required the services of 4.5 FTE, but the prices in the final proposal submitted by the affiliate was for the services of 4.375 FTE at the same cost as the affiliate had requested in its September 4 funding request. Because of the absence of a decision by VA that its requirements were less than stated in the solicitation, it appeared that the change in FTE by the affiliate was to accommodate the affiliate, not VA.

2. In another pre-award review, we requested data from the affiliate to support the costs in its proposal. Upon receiving the request, the affiliate contacted the VA Service Chief, who not only had requested the contract with the affiliate but also was going to provide services under the contract. In response to the affiliate, the VA Service Chief then confronted the contracting officer and challenged his authority to request the pre-award review. We were subsequently contacted by the Service Chief's Administrative Assistant, who expressed concern that we were conducting the pre-award review because the Service had been negotiating the contract for a year. The contracting officer was not involved in those negotiations.

3. A solicitation for Otolaryngology services originally was written for services to be provided on an FTE basis. However, documentation shows that the requirements were changed to a daily rate calculated using Relative Value Units at the request of the affiliate. Documentation also shows that the affiliate added requirements ensuring full payment even if a full day of service was not required and that the physicians could work at the affiliate on days they were not needed at VA but were being paid by VA. Correspondence in the contract file shows that the Administrative Assistant to the Chief of Staff, not the Contracting Officer, was responsible for the development of, and changes to, the solicitation.

4. VA issued a solicitation containing a requirement for eight FTE for radiologists. The proposal submitted by the affiliate was for 11 FTE. The medical center could not provide any justification for the services of the additional three FTE. There was no provision in the solicitation for VA to monitor the services provided to ensure it received the services of 11 FTE or to off-set payment if less than 11 FTE were required.

5. A VA medical center submitted a solicitation for our review in which the stated requirement was for "surgical services." The solicitation did not delineate the type of service, e.g., general, neurosurgical, thoracic, cardiovascular, which is needed to determine cost reasonableness. We advised the medical center that it would have to conduct a workload analysis to determine the number of FTE for each surgical specialty.

The solicitation was not issued and the services were subsequently procured on a fee-basis arrangement.

6. A recent proposal from an affiliate included the services of administrative support personnel. In response to our inquiry whether these services were feasibly available to VA as direct hires, we were advised by VA personnel that the contract physicians preferred to work with particular individuals who were employed by the affiliate; therefore, the services would be provided under the contract. VA personnel told us that they did not want to “rock the boat” by saying “no” to the affiliate and amended the solicitation accordingly. The amendment included the addition of an FTE that, unbeknownst to VA, was already performing duties at VA at the affiliate’s direction. The file also contained documentation showing that the negotiations were completed after discussions with the affiliate regarding contract requirements and other terms and conditions, prior to VA even requesting a proposal. In fact, the price negotiation memorandum, which is usually prepared after contract negotiations are completed, was prepared the same day the solicitation was issued to the affiliate for a proposal. The changes to the solicitation to add administrative personnel increased contract costs by approximately \$65,500.

In both our pre-award and CAP reviews, we have seen solicitations that have been amended electronically by the affiliate to add, modify, or delete clauses. Since these appear in the same type as the original solicitation, they go unnoticed. For example, a solicitation issued by VA contained FAR clause 52.212-4 which contains 20 subparagraphs. In submitting its proposal, the affiliate added an additional subparagraph to the solicitation addressing its termination rights and other requirements.

Solicitation Terms and Conditions Often Do Not Protect VA Interests

Our pre-award reviews include an in-depth review of terms and conditions of the solicitation and how responsive the proposal is to the solicitation’s requirements. While proposed pricing may appear reasonable at first, the terms of the contract affect whether its pricing will remain reasonable during the term of the contract. No price reasonableness determination can be made if the services to be provided under the contract are not clearly defined. Moreover, price reasonableness cannot be maintained during the term of the contract if the contract document does not specify how contract compliance will be monitored and does not provide for an off-set or penalty if the requirements are not met. We have identified the following issues:

1. **Physician Presence:** Work hours in most FTE based solicitations are well defined; the most common being 8:00 am to 4:30 pm with a requirement for 24-7 coverage. However, the solicitations do not specify how VA will monitor time and attendance to ensure that VA received the services being paid for under the contract. With respect to on-call coverage, solicitations do not state whether call-backs or other work performed

during non-work hours are, or can be counted against, the days the physicians are expected to be present.

Two proposals sent in for pre-award review included the following paragraph:⁵

“On duty days, the contract anesthesiologists shall be on site at 6:15 am on Tuesday and 7 am on Monday, Thursday, and Friday to facilitate an efficient start of the surgical day and to participate in scheduled conferences. On Wednesday morning, the contract anesthesiologists are expected to participate in Anesthesia Grand Rounds. On duty days at the VA, the contract anesthesiologist shall be fully committed to VA patients and shall have no non-VA responsibilities. Contract physicians are expected to devote the time necessary to deliver the highest quality services to the VA patients. When surgery and the anesthesiologist’s duty to the patient, as well as required documentation, are completed for the day, the contract anesthesiologist may leave VA without contract penalty, except that all on-call requirements must still be met.”

We expressed concern about this clause for several reasons. First, there was no assurance that VA would receive the services of the number of FTE paid for under the contract. The affiliate, not VA, controlled the scheduling of the physicians and there was no provision for VA to monitor time and attendance. Also, the terms and conditions did not require that all the contract anesthesiologists would either be “on duty” at VA or on approved annual, sick, or administrative leave. In fact, the only day of the week when all the contract physicians were required to be present was Wednesday, for Anesthesia Grand Rounds.

The second issue we raised was with the provision that the anesthesiologists could leave VA without contract penalty once their responsibility to the patient and required documentation was completed. This means that if the workload on any given day did not require the services of the FTE paid for under the contract for any or all of the day, the anesthesiologists could leave and work at the affiliate. As a result, the contract anesthesiologist would be in a position to generate income for the affiliate or the practice group that would not be subject to an off-set for the physician’s salary and benefits because they were paid for by VA under the contract. Third, although the statement of work required the contract anesthesiologists to perform administrative duties, such as quality assurance activities, the time and attendance clause in this contract clearly did not require them to perform any activities at or for VA other than patient care and Anesthesia Grand Rounds.

⁵ In another matter that was not sent in for a pre-award review, the VHA Resource Sharing Office mandated that the contracting officer include this paragraph in the contract.

Solicitations generally identify the VA facility as the place of performance for FTE based contracts. However, contract specifications are not always clear that the physician must be present at the VA and actually performing the services contemplated by the contract in order to be paid. Additionally, there have been solicitations, especially for radiology services, that allow the contracted physician to perform the reading of the films via electronic transfer to the affiliate. This causes concern because the physician is not available at the VA facility if needed, and also would be unavailable to fulfill any teaching requirement that may be specified in the solicitation. Even if a solicitation contained a time and attendance provision to ensure VA obtained the services of the FTE provided, the provision would be useless if the contract personnel are not present at VA.

2. On-Call and Emergency Call-Back Provisions: All of the solicitations we have reviewed for services to be provided at VA contain requirements for on-call coverage and emergency call-backs. We have raised concerns that the on-call and call-back requirements do not specify that the contractor personnel shall be fully dedicated to VA when on-call. When we have inquired about the on-call provisions, we were told by VA and affiliate personnel that the contract physicians who are on-call at VA are concurrently on-call at the affiliate. In our view, this presents a potentially serious quality of care issue that could impact care to veterans if the contract physician is caring for patients at the affiliate and is unable to respond when called to provide care to a VA patient. We are aware of at least one medical malpractice claim against VA where the on-call physician was in surgery at the affiliate when needed at VA. With respect to emergency call-backs, the requirements do not always specify response time requirements and, if they do, the solicitation does not specify a contract adjustment or penalty for failure to adhere to the response requirement. Call-backs should generally occur within 30 minutes, but can vary by medical specialty.

3. Penalties for Non-Compliance: Solicitations either fail to address penalties for non-compliance or do not provide adequate remedies for the Government. The following are two examples of this problem:

- Solicitations for surgical or anesthesia services either do not contain penalty provisions or limit the penalties to off-sets of a day's pay if surgeries are cancelled. We have recommended that the amendments to the solicitation include penalties to reimburse VA for reasonable costs associated with any cancellations due to non-performance. In addition to the effect cancellations may have on the patients, the cancellation and rescheduling of procedures result in costs to VA beyond the salaries paid to the contract physician, because surgical procedures necessarily involve the efforts of more than one discipline. Costs incurred by VA can include pharmaceutical, medical/surgical supplies and equipment that may have been used, discarded, or re-sterilized; salaries of physician, nursing, and operating room support staff; and additional patient care costs, such as laboratory costs, additional length of stay, etc. The affiliate should be assessed for costs

incurred for any delays caused by the failure to provide services under the contract.

- Solicitations for radiology services either do not specify timeframes for interpreting x-rays and other diagnostic procedures or do not contain penalties if the established standards are not met.

4. **Duties and Responsibilities are Not Clearly Defined:** Statements of work generally state that the contract employees will have clinical, administrative and, in some cases, research responsibilities. However, the percentage of time expected to be devoted to each is not defined. Rather, it is left to the discretion of the affiliate, which is responsible for scheduling the contract employees. This is significant because the amount of time devoted to non-clinical duties impacts on the number of FTE required to provide direct patient care. With regard to research, we have not seen any solicitation that specifies what percentage of time will be devoted to research, where the research will be performed, whether the research must be VA related and approved, or that VA will receive any credit for or rights to the outcome of the research.

5. **Approval for Treatment in Excess of Contract Terms:** Solicitations for in-patient services to be provided at the affiliate contemplate the return of the patient to VA after the procedure, but prior to discharge. Because pricing is based on length of stay, the solicitations delineate a specific number of days that the patient is expected to be cared for at the affiliate. In order for the affiliate to receive payment for lengths of stay that exceed the number of days specified in the contract, VA must approve the additional care. One of the primary issues we have identified with the terms and conditions in these solicitations relates to the absence of specific procedures or a process for obtaining VA approval.⁶ One solicitation specifically provided that approvals for care in excess of the time frame specified in the contract for heart transplants had to be in writing from the Chief of Staff. However, the process for other procedures covered under the contract, such as left ventricular assist devices, did not specify that the approval had to be in writing. As a result, a dispute arose when VA declined to pay invoices submitted by the affiliate for care provided to patients in excess of the number of days specified in the contract. The affiliate argued that the process was the same as it has always been. A requirement for written approval of all procedures would protect VA from unnecessary litigation.

Lengths of stay in excess of what is specified in the contract are usually requested by the affiliate because the patient needs care that VA cannot provide. In the situation described above, the affiliate justified the additional days by describing care that the patient required that precluded transfer back to VA.⁷ We have recommended in our pre-award

⁶ The second issue we identified relates to potential violations of Federal conflict of interest law. This issue is discussed in Issue 3.

⁷ The reasons included mechanical ventilation, medications, and lack of resident coverage at VA.

reviews that medical centers identify criteria that would preclude transferring the patient back to VA. These criteria should be addressed in the request/approval process between VA and the affiliate. In addition to resolving payment disputes, the use of criteria will ensure that decisions will be made with a complete understanding of the patient's condition and treatment needs, and decrease the risk that the patient would suffer an adverse event that could result if transferred prematurely.

6. Pre-award Reviews are Often Not Requested: VHA Directive 99-056 requires a pre-award review of all sole-source procurements in excess \$500,000 inclusive of all option years. During FY 2002, we received requests to review 18 offers. Data obtained from the Resource Sharing Office report identified 78 sole-source awards to affiliated institutions with a value in excess of \$500,000 that should have been sent in for a pre-award review. If the information reported to the Resource Sharing Office is correct, we received only 23 percent of the offers that met or exceeded the review threshold. FY 2003 data provided by the Resource Sharing Office listed 99 sole-source contracts with affiliates valued at greater than \$500,000. Of the 99 contracts listed, only 3 (3 percent) were sent to us for pre-award review.⁸

The award data maintained by the Resource Sharing Office shows that in FY 2003, sole-source contracts awarded to affiliates under §8153 were valued at \$197 million. Our pre-award reviews have identified, on average, 21 percent BUOF. Applying the 21 percent BUOF to the universe of contracts awarded in FY 2003 would have resulted in potential cost savings of \$41 million. Applying the 62 percent average savings sustained during contract negotiations, estimated cost savings would have been \$25.4 million for FY 2003.

7. Other issues relating to contract compliance include:

- Price negotiation memoranda showing that price negotiations have commenced sometimes accompany the request for a pre-award review. It is not appropriate that negotiations of contract prices occur before a pre-award review is concluded. If the pre-award review identifies areas where proposed costs could be reduced, the offeror is unlikely to be receptive to renegotiation.
- Representations and certifications are not always completed as required by FAR 52.212. During FY 2003, 5 of the 27 proposals reviewed did not include the required representations and certifications.
- On occasion, awarded contracts have been forwarded for a pre-award review. During FY 2003, 4 of the 24 proposals reviewed had been awarded prior to

⁸ In FY 2003 we conducted 24 pre-award reviews of proposals, each of which was valued at more than \$500,000. We could only identify 3 of the 24 in the data compiled by VHA's Resource Sharing Office. We contacted the individual responsible for maintaining data for the Resource Sharing Office and were advised that all the data had not yet been compiled and, as such, was incomplete.

requesting a pre-award review. This is significant because once a contract has been awarded it is difficult to reopen negotiations. Also, VA does not have any leverage in renegotiating the contract if it does not have a contingency plan in the event negotiations are unsuccessful.

- While compliance with signing offers has improved significantly, un-signed offers are still forwarded for pre-award review. During FY 2003, 4 of 27 proposals submitted for review were not signed by the offeror. An unsigned offer is not binding on the offeror.
- The solicitation package should be submitted for legal and technical review before issuing the solicitation. VHA Directive 99-056 stipulates that proposed contracts must be sent to the VHA Office of Finance, Sharing, and Purchasing Office for technical, legal, and program office reviews. Although the directive does not specifically indicate that this should be performed prior to issuance of the solicitation to the affiliate, the solicitation should be legally and technically sufficient and meet the program office's needs prior to being issued to the affiliate for a response.

Conclusion

The details of the issues presented above led us to the conclusion that improvements are needed in general contracting issues as follows:

Recommended Improvement Action(s) 1. We recommend that the Acting Under Secretary for Health take the following actions:

- a. Require VA facilities to conduct and document adequate acquisition planning by:
 - Assembling an acquisition team, which includes the contracting officer, as required by VAAR 873.105.
 - Justifying the need to contract for physicians and other health care providers as opposed to hiring them directly and, if contracting is required, justifying the need for a sole-source contract with the affiliate versus competitively contracting for these services. The justification should include comparison of compensation packages (salary and benefits) for providers doing the same level of work in the local area, not just the affiliate, and documentation of efforts to recruit.
 - Ensuring that there is adequate lead time for acquisition planning. We recommend 6-9 months for a new requirement and 3-6 months for a renewed requirement.

- Ensuring that the procuring facility has an alternate plan to obtain the necessary services in the event VA cannot negotiate fair and reasonable pricing, or terms and conditions with the affiliate.
- b. Develop a standard that defines the patient care workload expected from one FTE for a given specialty in terms that can be applied by the contracting community to determine the number of FTE required to provide a given amount of health care under the contract.
- c. Require competition for the procurement of health care services unless VA is a participant in an active residency training program in the specialty being procured.
- d. Ensure that legal and technical reviews are conducted before the solicitation is issued.
- e. Ensure that pre-award reviews by the OIG Contract Review and Evaluation Division are obtained for all proposals valued at \$500,000 or more, inclusive of option years, before contract award.
- f. Develop and implement policies that will ensure that contracting officers fully understand the services and responsibilities of the departments (e.g., radiology, anesthesiology, etc.) for which they are obtaining services.
- g. Ensure that contracting officers have independent authority for ensuring all contracts awarded to affiliates are in compliance with Federal and VA acquisition regulations, and are in the best interests of the Government.
- h. Develop and implement a national policy establishing requirements for recruiting by VA for VA positions to minimize the need to contract for health care services.
- i. Restrict the electronic sharing of solicitations to “read only,” to ensure that terms, conditions, and other clauses cannot be amended by the entity submitting a proposal.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. Details of his response are shown in Appendix C, pages 70-83.

Office of Inspector General Comments:

The Acting Under Secretary for Health comments met the intent of the recommendations. We will continue to follow-up on all planned actions until all of the issues have been resolved.

Issue 2: Contract Pricing

Findings

The requirements for services to be provided under these contracts are described in the solicitations as either FTE or procedure based. We have reviewed solicitations for services to be provided at VA that are FTE based, procedure based, or a combination of the two. For services to be provided at the affiliate, the solicitations have all been procedure based. Because the cost analysis for FTE based contracting is substantially different from the analysis used for procedure based contracts, we will discuss them separately.

There are at least two common findings relating to both FTE and procedure based contracts. The first is that VA is paying more than fair and reasonable prices under both types of contracts, which results in substantial profits for the affiliates. The absence of an acquisition plan that includes an alternative to a sole-source contract with the affiliate, if fair and reasonable pricing cannot be negotiated, leaves VA with no option but to pay more than its fair share of the costs. The second commonality is that VA personnel at certain facilities have become so dependant on the affiliate that they either refuse to, or believe they cannot, look for other sources, including hiring directly. This is due, at least in part, to the fact that VA physicians involved in the contracting process have a relationship with the affiliate. In fact, they may have an interest in the award of the contract, because they will be providing services at VA under the contract at an increased rate of pay.

Our concern with procedure based contracts is that the manner in which VA facilities are using Medicare rates as the basis for establishing contract prices results in VA paying more than Medicare would pay for the same services. Based on our discussions with VA personnel, we have identified several reasons for this condition. First, many VA personnel responsible for these contracts, are not familiar with the components of the Medicare rates. They are also not familiar with the relationship of the rates to the services to be provided at VA, or for VA at affiliated institutions. Second, we discovered that many VHA personnel are not familiar with CMS regulations pertaining to payments under Medicare Part A, inpatient hospital services, and Medicare Part B, physician services. These regulations define what services are compensable and the circumstances under which payments are appropriate. Lastly, many VHA personnel involved in these contracts believe that they have no choice but to accept the terms and conditions, including basis of payment, proposed by the affiliates.

FTE Based Contracts

In conducting pre-award reviews of FTE based contracts, we request data from the affiliate to support the proposed prices. Once the information is received, we conduct a cost analysis which includes identifying the individuals expected to provide services under the contract, the level of effort the physicians are expected to furnish to VA under the contract compared to the level of effort expected to furnish services at the affiliate, the compensation packages (salaries and benefits) of these personnel, overhead costs, additional payment for call time, and profit.⁹

Using a National Database to Determine Fair and Reasonable Pricing

We were advised by the VHA Resource Sharing Office of a draft policy directive designed to establish nationwide standards for determining fair and reasonable contract pricing. We have been told that the Resource Sharing Office's most recent proposals for changing current policy were developed at the request of the former Under Secretary of Health. For FTE based contracts, VHA proposed using the American Association of Medical Colleges (AAMC) national salary base for medical college faculty for contract pricing. In a February 10, 2003, letter to the Senior Vice President for AAMC, the former Under Secretary for Health stated that he preferred using AAMC's data as a basis for negotiations compared to "...our policy that requires certified cost and pricing data from the medical college or conducting pre-award audits by our Office of Inspector General." In his letter, the former Under Secretary for Health further stated that AAMC's data base would satisfy VHA's interest for a national standard, allow a less labor intensive process, and provide a more robust source of comparison than our current practices.

The Resource Sharing Office told us that VHA would identify as a fair and reasonable price a percentile of the salary rates in the AAMC data base for each specialty. This was reflected in the most recent draft policy directive, which provided that the 50th percentile or less would be considered fair and reasonable. We do not believe that the AAMC rates are a reliable source to determine price reasonableness and, therefore, should not be used. FTE based contracts should be based upon the actual costs incurred by the affiliate to provide the services.

The AAMC data shows that in many specialties there is a significant variation between the salaries between the 25th and 50th percentile and the 50th and 75th percentile. For example, in the national database the reported salaries for orthopedic surgeons at the 25th, 50th, and 75th percentiles are \$232,000, \$291,000, and \$374,000 respectively. If VA paid at the 50th percentile and the individual providing the services was paid at the 25th percentile or less, VA would be paying at least \$59,000 more than the affiliate was

⁹ Another issue is the payment of malpractice premiums which is addressed in Issue 3 of this report.

paying the physician in salary and benefits. If the 75th percentile was used to establish pricing and the individual providing the services was paid at the 50th percentile, or less, VA would be paying at least \$83,000 more than the affiliate paid the physician. Similarly, in Thoracic and Cardiovascular Surgery the published rates at the 25th, 50th, and 75th percentiles at the Associate Professor level are \$270,000, \$340,000 and \$422,000 respectively. If prices are set at the 50th percentile and the contract physician is paid at the 25th percentile, or less, VA would be paying at least \$70,000 more than the affiliate paid the physician. If prices were established at the 75th percentile and the contract physician was paid at the 50th percentile or less, VA would be paying at least \$82,000 more per year than the affiliate paid the physician.

In addition to the wide variations in reported salaries, our discussions with AAMC and our review of the methodology used to collect the data raises additional concerns. These include:

- The surveys are voluntary and do not necessarily reflect the salaries of all physicians in any particular specialty or at any specific academic level. AAMC only requires five faculty survey responses to determine a pay band for a particular rank and physician specialty. Five responses do not adequately reflect the true market conditions at the regional or the national level.
- AAMC reported salary figures can include “uncontrolled outside earnings,” which do not relate to the services provided to the affiliate, its practice group, or VA.
- AAMC does not define what constitutes a full-time faculty member. As we have seen in our pre-award reviews, there is wide disparity in the level of effort required of a full-time physician between affiliates and within a practice group.
- AAMC national salary data is broken down into four regions – Western, Midwest, Southern Region, and Northeastern. These areas are so geographically diverse that AAMC admits that the data may not be applicable to all markets within a region. As an example, AAMC cited the Northeast region which includes data from Vermont and New York City. Because these two regions are very different with respect to the local physician compensation market, it would be difficult to apply the survey results to both areas interchangeably.

We have conducted one pre-award review of a proposal in which pricing was based on the median percentile of the rates in the AAMC data base for the specialty. Our review, which included an analysis of the actual compensation packages, overhead costs, and other related allocable costs, showed that the proposed prices were approximately 20 percent higher than the actual costs to the affiliate. Absent specific data to show otherwise, we have concluded that the use of AAMC data to establish a national standard for contract pricing is not in the best interest of the Government. Of related concern, the

draft VHA policy directive would not require a pre-award review until the FTE based contract exceeded the 75th percentile of the AAMC rates, which, if adopted, would essentially eliminate pre-award reviews.

Firm Fixed Price Versus Cost-Reimbursement Contracts

Problems with determining whether the prices offered are fair and reasonable are complicated by the fact that the OGC has determined that contracts awarded under §8153 are commercial item contracts. FAR Part 12.207 requires that commercial item contracts be firm-fixed price contracts. This means that all costs the affiliate may potentially incur in providing the services are negotiated up front and are paid even if the expenses are not incurred. For example, proposed prices may include a training allowance, incentive pay, or awards for each of the physicians who are expected to provide services under the contract. Proposed prices have included an estimated annual incentive pay as high as \$200,000 for one physician. However, there is no assurance that any of the physicians who provide services at VA will actually be paid the amount included in the fixed-price contract, or that the basis for the incentive award will be related to performance at VA.¹⁰ The same is true for training allowances. We have seen allowances as high as \$8,000 per year per physician. Under a firm-fixed price contract, VA pays the \$8,000 whether the physician uses the funds for appropriate training or not.

VA has the option of using 38 U.S.C. §7409 to award sole-source contracts to affiliates. We believe that this section provides VA with greater flexibility in choosing the appropriate contract type and have recommended this to program officials on several occasions. For example, whereas §8153 limits VA to firm-fixed price contracts, §7409 would allow VA to use a cost-reimbursement type contract under which VA would be able to reimburse the affiliate only for those costs actually incurred to perform under the contract. We recommend that VA use §7409 when awarding sole-source contracts to the affiliate.

Identification of Key Personnel Expected to Provide Services

Our pre-award reviews have shown that there are significant variances in the compensation packages offered to physicians within a single practice group. Therefore, any evaluation to determine the reasonableness of proposed prices necessarily starts with identifying the individuals who will be providing services under the contract. Some proposals identify specific individuals who will provide the services requested. For example, in response to a solicitation requesting two FTE, a proposal may identify two specific physicians who will perform all the requirements, or it may identify more than

¹⁰ In response to inquiries regarding how incentive pay or bonuses are paid or distributed, we have learned that this is essentially profit sharing. Each practice group has a mechanism for determining how much each member of the group will receive. For example, one practice group divided the funds based on how much on-call and call-back time each physician did during the year.

two physicians and specify what portion of the FTE requirements each will perform. When the physicians and the level of effort each is expected to provide are delineated in the proposal, the cost analysis is fairly straightforward because the data used to evaluate the reasonableness of the offered prices, (e.g., physicians' salaries and benefits) is readily identifiable. However, this is often not the case.

It is common for an affiliate to identify multiple individuals, or its entire pool of physicians within the requested specialty, as eligible to perform some portion of the work requirements and to base proposed prices on an average of the compensation packages for the pool. In our reviews of proposals that fail to identify key personnel and/or the level of effort each potential provider is expected to perform, we have raised concerns about the inability to determine whether the proposed costs are fair and reasonable. We have found significant variances in the salary structures for individual physicians employed at individual affiliates and even within those at the same academic rank levels (e.g., professor, associate professor, and assistant professor).

The following are examples of how the failure to identify a minimum number of specific individuals to provide services results in excessive costs:

- In response to a solicitation for 3 FTE interventional radiologists and 8 FTE general radiologists, an affiliate proposed an annual cost (salary and fringe benefits) of \$418,000 per FTE for 3 FTE interventional radiologists and \$395,000 per FTE for 10 FTE radiologists. Because the solicitation did not specify the requirements by academic rank or include a key personnel provision, the affiliate included its pool of radiologists without regard for academic rank and without delineating how much time each physician would be dedicated to fulfilling VA contractual responsibilities. Our review determined that the pool for the interventional radiologists consisted of seven physicians whose annual salaries ranged from \$263,000 to \$441,000. The affiliate averaged these costs to reach the proposed price of \$418,000 per physician. Using data from the previous contract period, we determined that only 3 of the 7 physicians actually provided services under the prior agreement. We then calculated their individual salary and benefits packages, which ranged from \$386,000 to \$387,000 annually. If VA had accepted the proposed price of \$418,000 per physician, VA would have paid approximately \$32,000 more per year per FTE than the affiliate would have paid the physicians in salary and benefits.

Similarly, the pool for the general radiologists consisted of 19 physicians of whom we determined that only 5 actually provided services at VA under the prior agreement. Our review found that the annual costs for the pool ranged from \$146,000 to \$396,000, while the range for the five physicians actually providing the services to VA ranged from \$262,000 to \$365,000, with an average cost of approximately \$350,000. The affiliate had proposed a cost of \$395,000 per FTE.

If VA awarded a contract with the costs proposed by the affiliate, VA would have paid at least \$45,000 more per year per FTE for the five FTE that provided the services than the affiliate would have incurred in costs associated with payment of compensation packages for these physicians.

In addition to concerns regarding the identification of key personnel to determine price reasonableness, the proposal also raised questions as to whether VA needed the services of the 10 FTE general radiologists proposed by the affiliate. During the prior year, the services had been provided by five FTE general radiologists. The solicitation called for an increase to eight FTE general radiologists, but there was not sufficient documentation that the workload required the increase in FTE. The affiliate's proposal was for 10 FTE general radiologists, which was 2 FTE more than the solicitation requested and twice the number from the previous year, without any justification for the increase. Assuming the workload did not require the services of 10 FTE, as proposed by the affiliate, VA would have incurred at least \$395,000 in salary and benefits per FTE, whose services may not have been required.

- Solicitations issued by VA may include FTE requirements that identify the academic rank of the individuals needed to perform under the contract. If the affiliate is not required to identify the specific individual(s) who will provide services under the contract and assign a percentage of the requirement to each individual, VA is at risk for paying more than the affiliate pays the contract employees for the work performed. This can occur because the terms of the agreements provide that the affiliate, not VA, schedules the providers. This gives the affiliate the opportunity to schedule physicians who earn less than the contract rate. If the affiliate assigns physicians at the lower end of the pay scale to VA, but prices are either based on the average or median salary, VA can pay more than its fair share of the costs incurred by the affiliate in the salary and benefits paid to the physicians providing the services. The chart below shows that there can be significant variances in salaries and benefits within the academic ranks.

Affiliate	Associate Professors	Variance	Assistant Professors	Variance
A	\$231,000 - 281,000	\$ 50,000	\$158,000 - 257,000	\$ 99,000
B	156,000 - 233,000	77,000	108,000 - 228,000	120,000
C	168,000 - 278,000	110,000	171,000 - 258,000	87,000

In addition to costs, we have concerns about the potential impact on quality of care when there is a lack of continuity at the attending physician level. As noted above, in solicitations that do not require the identification of key personnel, the affiliate, not VA, is responsible for scheduling the contract providers. For those services that require continuity of patient care (e.g., pre-operative, post-operative, and follow-up care), this process does not provide any assurance that veterans will be cared for by the same

provider over the course of their treatment. This presents a risk of harm to veterans and may further increase costs to VA.

We recommend that all FTE contracts identify key personnel who will provide the required services and that the terms and conditions of the contract prohibit the affiliate from changing key personnel without VA approval. The following provisions, which were included in a contract awarded by the VA Medical Center, Little Rock, Arkansas, are considered a best practice example of how this can be achieved:

- Before removing, replacing, or diverting any of the listed or specified personnel, the Contractor shall (1) notify the Chief of Anesthesia and/or the Contracting Officer reasonably in advance and (2) submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on this Contract.
- The Contractor shall make no diversion without the Contracting Officer's written consent; provided that the Contracting Officer may ratify in writing the proposed change, and that the ratification shall constitute the Contracting Officer's consent required by this provision.
- With the consent of both Contracting parties, the list of specific personnel may be amended by the Central Arkansas Veterans Healthcare System (CAVHS), Contracting Officer to add or delete personnel. When a modification of personnel is made, a recalculation of salary line and associated benefit costs may result in a modification in the reimbursement by FTE.
- With the absence of one of the specified personnel, the contractor shall provide another qualified physician to work during that period, so that uninterrupted patient care will be maintained for the CAVHS veteran patients. The office of the CAVHS Chief of Anesthesia will notify University of Arkansas Medical School, Department of Anesthesiology when an absence will occur. This additional coverage will be ordered pursuant to Contract line item numbers.

By identifying key personnel and limiting the contractor's authority to make unilateral changes, these contract provisions protect the interests of the veterans and the Government.

Level of Effort Considerations When Defining an FTE

Another issue we consistently have encountered in reviewing solicitations and proposals is defining the work requirement or level of effort for an FTE. Our concerns vary depending on the number of physicians providing the services and the manner in which the services are to be provided. If the proposal identifies the minimum number of physicians required to meet the requirement (e.g., three physicians will meet the requirements of three FTE and the individuals are dedicated to VA and not expected to provide services for the affiliate or the affiliate's practice group, including participating in non-VA research projects), determinations supporting fair and reasonable prices are fairly straightforward.

The common practice is for physicians not to be dedicated to provide services at VA under the contract, but to provide services part-time for VA and part-time at the university or the affiliate/practice group. It is also a common practice for part-time VA physicians to also provide services at VA under the contract. We have raised concerns about the level of effort required per FTE when the physicians are not dedicated to providing services at VA. Following is one of the most common scenarios found in proposals:

- A minimum number of physicians are identified to provide services under the contract, and the prices proposed include the total compensation package for each physician. However, in addition to the level of effort each physician is expected to provide at VA under the contract, each physician is expected to provide services for the affiliate. These services generate income for the affiliate and/or practice group, with no off-set to the costs paid by VA under the contract. Here is how VA ends up over paying for the physician compared to the level of effort he is expected to provide to earn the full compensation package. VA defines an FTE as 8 hours a day and believes strongly that if they require 1 FTE and receive services 8 hours a day/5 days per week that VA is obligated to pay 100 percent of that physician's compensation package, which often includes incentive payments or bonuses in addition to base salary.¹¹ However, our reviews have shown that it is a common practice for the affiliate to expect or require that the physician work a 50-60 hour work week to earn his or her agreed-upon compensation package.¹² In our opinion, VA should only be obligated to pay that portion of the physician's salary and benefits that relate to the percentage of time spent providing services at VA. If during any contract year, the physician, who works on average 60 hours per

¹¹ Incentive payments and/or bonuses are quantified in proposals or in data provided to support the proposals. However, the amounts are not quantified in the agreements between the physician and the university and/or the practice group.

¹² In at least one case, the contract between the physician and the affiliate specified the number of hours the physician was expected to work. The agreements specified an average of 55 or 60 hours per week depending on the physician.

week, spends two-thirds of his time at VA (e.g., 40 hours per week), and one third of his time at the affiliate (e.g., 20 hours per week), either providing care or conducting non-VA related research, VA should only pay two-thirds of the physician's total compensation package.

When we have raised the issue of the average number of hours the physician either works or is expected to work to earn his or her full salary and benefits (which often includes incentive payments), some affiliates have been less than forthcoming with the information. For example, an affiliate's representative initially told us that the physicians worked 55-60 hours per week. However, when advised that these figures would be used to calculate the percentage VA would pay, the affiliate's representative modified his previous statement and indicated that the providers only worked on average 40 hours per week. However, when we asked the representative to put this in writing, he declined.

We have found that VA facilities and their affiliates not only calculate hourly rates using a 40-hour week, but also exclude the maximum time off that the physician may take during the year. This practice serves to further inflate the costs paid by VA. As stated previously, under most FTE based contracts, the affiliate, not VA controls scheduling. We have found that affiliates are converting a single FTE requirement for service provided at VA to one plus some other portion of an FTE that is determined by the affiliate. The one plus FTE is generally derived by calculating the maximum time off that any physician may take using annual, sick, or administrative leave, (e.g., for training), and increasing the requirement by that amount. For example, if VA defines an FTE as 2,000 hours, the affiliate may decide that a single physician, if he takes the maximum amount of paid time off, would be able to provide 1,800 hours. The affiliate then adds 200 hours to the 2,000 hours VA defined per FTE and determines that 1.1 FTE will be required. As a result, in a fixed price contract, VA pays for time off for the physician whether it is taken or not, as well as paying for a "substitute" physician who may not be needed.

Compensation Packages

We have found that the compensation packages, which include salary, benefits, and other monetary payments for physicians, vary significantly from facility to facility. The compensation amount in agreements between physicians and the affiliate and/or the practice group can be a fixed amount, be based entirely on income generated, or a combination.¹³ The majority of agreements we have reviewed include separate salary and benefits packages from the practice group and from the university, with no consistency between institutions or even within a specialty. For example, the following chart shows the disparity at one affiliate within one surgical specialty:

¹³ In most cases where the university has a practice group, there are separate agreements between the physician and the university and the physician and the practice group.

Physician	Total Base Compensation	Percent from University	Percent from Practice Group
A	\$283,370	44.98	55.1
B	470,540	0	100.0
C	185,870	68.4	31.6
D	302,555	34.3	65.7
E	320,000	44.2	55.8

We question whether VA should be paying the portion of the compensation package that relates to services provided to the university if they do not relate directly to the requirements in the contract for services to be provided at VA. This issue needs further review to determine what, if any, portion of the university component is related to the services required by VA under the contract and, therefore, can be properly included in the contract costs.

We also found that agreements between the physicians and the affiliate and/or practice group may contain a breakdown of the percentage of time expected to be spent in patient care activities, teaching, and research. However, this issue is generally not addressed in the proposed contracts between VA and the affiliate, and can result in higher costs to VA when the payment is based on FTE. The more time each FTE physician spends in non-clinical activities (e.g., research, training, and non-patient care teaching) a greater number of FTE is required to meet VA's patient care needs. We recommend that when determining the number of FTE required under the contract, VA identify what percentage of time each FTE will spend in patient care and non-patient care activities and include this in the solicitation.

We have not seen any contracts between VA and the affiliate that provide VA with any ownership or interest in research activities conducted by physicians who are being paid by VA under the contract. This is not a problem if VA is only paying a pro-rata share of the physician's compensation package and the hours spent for research are excluded from the VA contract. However, in those cases where VA is paying the entire compensation package for a physician, or a portion thereof based on an 1800 or 2000 hour work year, and the physician spends additional time conducting research at and on behalf of the affiliate with no additional compensation, VA is supporting the affiliate's research activities with no benefit to VA.

Overhead

In addition to costs associated with salary, benefits, and malpractice premiums for each physician expected to provide services under the contract, proposals often include anticipated overhead costs. Some affiliates do not include any overhead component in

their proposals, while others include questionable overhead costs. The most extreme example of the latter was a proposal in which prices were to be established at an hourly rate that was calculated based on the salary and benefits package and overhead expenses for each physician. As the chart below illustrates, the proposed overhead costs, which amounted to 96 percent of the average of the total costs, were more than excessive.

Physician	A Total Compensation	B Overhead	C Total Price to VA	B/A Percent Overhead
A	\$408,200	\$520,197	\$928,397	127
B	289,698	284,501	574,199	98
C	228,517	115,728	344,245	51
D	508,220	552,062	1,060,282	109
Average	358,659	368,122	726,781	103

The affiliate refused to provide any data to support the compensation packages and overhead costs cited in their proposal. Accordingly, we recommended that the contract not be awarded.

We also found proposals in which the overhead component of the proposed prices was calculated as a percentage of the proposed prices for FTE compensation. The most frequently used percentage was 5 percent. Based on our discussions with VA personnel, we concluded that this was done at the direction of VHA. However, we were unable to find any written guidance establishing this as an accepted practice.¹⁴ In addition, no one has been able to provide us any analysis or other evaluation showing that using a flat percentage rate across VA for all contracts resulted in fair and reasonable prices. We concluded that this methodology was recommended and used because it was faster and easier than requesting data showing the costs actually incurred in negotiating or administering the contract. In our pre-award reports and in the training we have provided to VHA personnel, we have taken the position that this is not an acceptable practice and recommended that allowable overhead be based on the costs incurred by the affiliate that are allocable to the contract.

In conducting pre-award reviews, we asked the affiliates to provide data to support proposed pricing for overhead. In response to our requests, we have seen a wide variety of costs included in the calculations, much of which was not incurred by the affiliate to provide the services under the contract. For example, for a proposal where all services

¹⁴ Some facilities told us that VHA management had recommended the percentage. Other facilities told us that the 5 percent was based on an OIG recommendation. However, no one could identify an OIG report containing the recommendation. We reviewed the IG reports relating to these contracts and could not find this recommendation.

were to be provided at VA, one affiliate pro-rated all of the overhead expenses incurred by the practice group, which included office space, furniture, administrative support personnel, utilities, office supplies, mailing costs, parking fees, etc., none of which was either used or needed for the contract physicians to provide services at VA under the proposed contract. When the services are provided at VA, the VA facility, not the affiliate, pays these costs directly.

FAR Part 31 establishes contract cost principles and procedures that are applicable to these contracts. We recommend that VA establish specific policy and guidelines identifying the costs that will be considered appropriate in determining properly allocable overhead costs in accordance with FAR Part 31. Having specific policies and guidelines will provide medical center and contracting officials with the support needed to negotiate with the affiliate.

Additional Costs for Call Coverage

In the last 2 years, we have seen a trend towards including prices for coverage during off-duty hours (i.e., on-call coverage). We have concluded that on-call requirements should not be an additional charge to VA under a contract unless the affiliates pay physicians for their on-call duty in addition to their base compensation packages.

We have found only one affiliate whose normal business practice was to pay physicians separately for on-call duty. The affiliate advised that to address the problem of physicians not performing their fair share of on-call duty, the practice group changed its salary structure. Instead of paying an annual salary, which included time spent on-call and being called back, the new salary structure included a rate of pay for each hour on-duty, including call-back time, and a separate hourly rate for time spent on-call. Although monitoring time and attendance spent on-call was administratively burdensome, the affiliate reported that the physicians became more accountable and willing to perform their share of on-call duty. None of the other reviews we have conducted, in which on-call time was billed as a separate line item, involved a similar pay structure at the affiliate or supplementation of the physician's salary for call duties. Rather, on-call duty was expected as part of the physicians' normal duties.¹⁵

However, in the one case where payment for on-call time was justified, we concluded that VA was overcharged, because a part-time VA physician was serving all of his VA on-call duty as an employee of the affiliate. The physician did not provide on-call services as part of his VA duties. The physician, who also worked part-time at VA as a service chief, was in a position to do less, or no, on-call as part of his VA duties, thus

¹⁵ However, during one pre-award review, the affiliate agreed to pay the physician the amount charged VA for on-call duty. We concluded this was done to ensure VA would agree to pay the proposed prices. Because this was not made part of the contract, we do not know whether the physician did, in fact, receive the additional compensation.

increasing the amount of on-call services procured under the contract with the affiliate.¹⁶ Both the physician and the affiliate benefited financially from this arrangement. During a 7-month period, the physician performed 1,061 hours of on-call time under the contract and no on-call time as a VA employee. Since the physician was 0.625 FTE for VA, we determined that 663 hours of on-call time should have been performed as part of his VA duties, which resulted in a contract overpayment of \$22,593.

We have been unable to identify any law, regulation, or VA policy that establishes the amount of on-call time a VA physician, either full or part-time, is required to perform as part of his or her VA duties and responsibilities. Therefore, when services are performed by both VA and contract personnel, many of whom are also part-time VA employees, there is no reliable basis to determine whether the on-call requirements of any contract adequately state VA's actual needs or whether VA is paying twice for the same services. As an example, we were contacted by a contracting officer asking whether it was appropriate to pay for weekend on-call services as a separate line item in a contract. The proposed price was \$500 per weekend. The contracting officer explained that the two part-time VA physicians would be providing services as VA employees for 8 weekends per year (4 weekends each) and coverage for the remaining 44 weekends would be purchased under the contract. In responses to our questions, we learned that the same two physicians would also be providing on-call services under the contract. We had no reason to object to the concept of the contract, because we could not determine whether 4 weekends per year per VA physician was acceptable or not since there are no standards.

We also learned that physicians who provided the on-call services under the contract would not receive compensation in addition to their basic salaries, and that the physicians would also be providing on-call services simultaneously at the affiliate. As discussed in Issue 1 of this report, this practice raises concerns about the quality of patient care. The fact that the physicians were expected to be on-call concurrently at both the affiliate and VA was not unique to this facility. The practice is consistent with what we have found in our pre-award reviews of other contract proposals that included additional payment for on-call services.

Profit

VA Directive 99-056 indicates that the affiliate can earn a profit through these contracts. Although we have seen proposed prices that far exceed the costs associated with providing the services, which results in a profit for the university and/or practice group, none of the proposals we have reviewed has contained a line item for profit, as required by FAR 15.404-4. Because the basis for allowing the awarding of these contracts on a sole-source basis to the affiliate is to maintain the mutually beneficial relationship involving the training of medical students and residents, we question whether the affiliate

¹⁶ As discussed in Issue 3, these actions may violate Federal Government ethics law. See 18 U.S.C. § 208.

should be making a profit off the VA. We believe the BUOF identified as a result of our pre-award reviews is a conservative example of the amount of profit affiliates can get paid under these contracts.

Procedure Based Contracts - Use of Medicare Rates

We have concerns about the use of Medicare rates and other procedure based methods of payment for medical care to be provided by contract providers, either at the VA facility or at an affiliated medical school. Our concerns are divided into two categories – contracts for services to be provided at VA and contracts for services to be provided at the affiliate.

Contracts for Services to Be Provided at VA

VA is Overpaying for Services

In FY 2003, we had an increase in the number of requests for review of procedure based proposals for services to be provided at VA medical centers.¹⁷ Of the 24 pre-award reviews requested and completed in FY 2003, 7 were procedure based proposals, of which 3 were for services to be provided at VA. The preference for procedure based contracting is due in part to VHA Directive 99-056 which states: “It is VHA policy that the preferred way of purchasing clinical services is through the use of procedure based contracts, with Medicare rates as the benchmark for procedure prices.” VA contracting personnel have told us that Medicare rates are preferred because they make the contract easier to award and administer. One program official told us that procedure based contracts were preferred because they eliminate the need to account for time and attendance. The methodologies that involve the use of Medicare Part B rates to establish contract prices for provider services vary.

Some examples of how Medicare rates are used include:

- Pricing is based on Medicare’s schedule for Current Procedural Terminology (CPT) codes using estimates of the number and type of procedures expected to be performed, not the actual procedures performed. In at least three reviews involving procedures to be performed at the VA, the affiliate, not the VA medical center, provided the estimated procedure information. One contract proposal included costs for administrative personnel whose duties were collecting and analyzing VA workload to prepare a procedure based proposal for a follow-on contract.

¹⁷ Of the nine pre-award reviews completed in FY 2002, three were procedure based proposals for services to be provided at the affiliate. Of the 20 pre-award reviews requested in FY 2004, seven were procedure based proposals, three of which were for services to be provided at VA.

- Pricing is based on a combination of CPT codes and FTE. For example, payment for surgical procedures is CPT-based while clinic days are paid on an FTE basis.
- Pricing is based on an estimated number of Relative Value Units (RVUs) which have been calculated using the CPT codes for an anticipated number of specific procedures and clinic visits. Annual contract prices are determined by multiplying a dollar amount per RVU by the estimated number of RVUs. In other proposals, an anticipated number of RVUs is used to identify the number of days that services are expected to be provided during the term of the contract and pricing is offered as a daily or monthly rate. In one contract, anticipated RVUs were used to calculate separate daily rates for surgical and clinical days. The affiliate added a condition to the solicitation that full payment would be made even when services were provided at VA for part of the day and the providers were working at the affiliate.
- The contract proposal or fee basis arrangement contains a fixed cost for the services to be provided, and Medicare costs for an estimated number and type of services are used as the basis for determining that the proposed pricing is reasonable.

We have identified several recurring problems with using Medicare rates for determining contract pricing or the reasonableness of pricing offered by the affiliate. To illustrate:

1. In the proposals we have reviewed, VA medical centers have inappropriately relied on the total Medicare Part B rates to establish prices or price reasonableness. We have not identified any situation in which it would be appropriate to use the total Medicare Part B rates to establish contract pricing or to determine price reasonableness when the services are to be performed at VA.

Medicare Part B rates are based on four components: physician effort, overhead expenses (e.g., office, technical or support staff, supplies), medical malpractice insurance, and a geographic adjustment. When all of the care and treatment is provided at VA, the overhead expense component must be excluded because VA, not the contract provider, provides the necessary space, utilities, support personnel, and supplies. We recognize that there are some overhead expenses that the contractor incurs in the administration of the contract. However, there is no consistency in the contracts and proposals that we have reviewed. Proposed overhead expenses have ranged from zero percent to more than 100 percent of salary and benefit packages for individual providers. Furthermore, we have not found a reliable way to identify reasonable overhead costs using Medicare Part B rates. Therefore, we have requested and/or recommended in our pre-award reviews that the affiliate provide documentation showing the overhead costs incurred in contract

administration, and that any supported costs be included as a separate line item in the contract.

If the provider is being paid as a VA employee under a fee basis or other similar arrangement, the medical malpractice insurance component also must be excluded. Because these physicians are Government employees, the Government is liable for any injury caused by the provider's negligence. As an example of impact, one VA medical center hired its surgical staff as fee basis employees. Each surgical specialty established a rate of payment based on procedures. To show that the rates were reasonable, the VA medical center compared the proposed fee basis cost to Medicare rates. At the time of our review, complete data was available for only a 1-month period. The data showed that VA agreed to pay \$273,500 for the services, which was significantly lower than the \$419,497 the medical center estimated it would have paid if the physicians charged VA at the Medicare Part B rate. We reviewed the procedures performed and adjusted the Medicare rates to exclude the overhead and medical malpractice components for the 1-month period. Eliminating these two components reduced the estimated cost, using Medicare rates, from \$419,497 to \$241,040 (42.54 percent). As a result, VA paid \$32,460 (\$273,500 minus \$241,040) more than it would have using the properly adjusted Medicare rate.¹⁸

As another example, the pricing for a contract for services to be provided at VA was 110 percent of Medicare Part B rates. In addition to paying the overhead costs included in the Medicare Part B rate, VA was to pay an additional \$28,000 to the affiliate for overhead. We analyzed the amount VA paid under the agreement for eight of the CPT codes listed in the solicitation and excluded the overhead component. As shown in the following chart, by including the overhead component and paying 10 percent above Medicare Part B rates without justification, VA overpaid approximately \$295,000 for these procedures, which represents about 27 percent of the value of the contract.

¹⁸ If Medicare rates were used, the comparable costs would likely be further reduced by excluding pre- and post-surgical visits that are included in the global rate for many surgical procedures. Sufficient data was not available for the 1-month time period to complete this level of analysis.

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER
AFFILIATED INSTITUTIONS

CPT Code	Estimated Number of Procedures	2003 Medicare Part B Rates	2003 Medicare Part B plus 10%	Cost at Medicare Part B plus 10%	2003 Medicare Part B Adjusted to Remove Overhead	2003 Cost Without Overhead	Difference Medicare Plus 10% Less Adjusted Rate
33405	65	\$1,966.53	\$2,163.18	\$140,606.70	\$1,278.69	\$83,114.85	\$57,491.85
33510	9	1,644.23	1,808.65	16,277.85	1,058.40	9,525.60	6,752.25
33511	15	1,728.86	1,901.75	28,526.25	1,096.52	16,447.80	12,078.45
33512	9	1,819.74	2,001.71	18,015.39	1,164.84	10,483.56	7,531.83
33533	231	1,707.85	1,878.64	433,965.84	1,094.93	252,928.83	181,037.01
33534	33	1,835.30	2,018.83	66,621.39	1,177.64	38,862.12	27,759.27
33536	2	2,052.04	2,257.24	4,514.48	1,356.59	2,713.18	1,801.30
33970	4	339.51	373.46	1,493.84	245.90	983.60	510.24
				\$710,021.74		\$415,059.54	\$294,962.20

2. With respect to per-procedure based contracts, in his February 10, 2003, letter to AAMC, the former Under Secretary for Health stated that “Medicare has appeal, though [he] appreciate[d] that it might not be a fair standard in some markets, especially for outpatient procedures.” He went on to state: “In some markets, I am willing to consider a percentage increase to the Medicare fee scale, similar to what is now done with Tricare contractors.” At a meeting in May 2004 with the Resource Sharing Office, representatives from OA&MM and OGC, we learned that one proposal would allow VA facilities to negotiate prices up to 150 percent of the established Medicare rates. The most recent draft of a VHA Directive also allows facilities to go up to the 150 percent of Medicare Part B rates before a pre-award review is required. We believe this proposal, if adopted, will result in VA paying significantly more than fair and reasonable prices for the services provided.

3. Medicare Part B rates for some procedures are global, in that they include certain pre- and post-procedure office visits, examinations, etc. When using Medicare Part B rates to either establish a contract price or to determine price reasonableness, VA medical centers and/or the affiliates count each interaction with the patient (e.g., pre- and post-operative office visits, the surgical procedure, and any subsequent procedures) as separate billable units. As a result, any cost estimates and/or payments are higher than they would be if Medicare Part B rates were applied. Because the average time to provide the treatment or perform the procedure is a large component of the Medicare rate, certain procedures done during an outpatient encounter are already included in the rate established for the outpatient visit. We have not identified any facility that has a mechanism in place to ensure that VA is not billed additional charges for care during the global time period, or

that charges related to encounters already included in the global rates are excluded in the analysis used to establish price reasonableness.

One post-award review included a review of the data collected by the affiliate that was used to establish proposed per diem rates for surgery and clinic days. The affiliate used CPT codes to establish an estimated number of RVUs that would be required to provide services to VA for surgery and for outpatient clinics. The RVU data was then used to determine the number of days that services would be required, and separate per diem rates were established for surgery and clinic days. To show that the rates were reasonable, the affiliate added the full Medicare Part A and B rates for each patient encounter and compared this number to the amount the affiliate proposed that VA pay under the contract. Because the services were provided at VA, Medicare Part A was not relevant, which resulted in grossly overstating VA's cost savings.

We reviewed the surgical procedures actually performed and sampled the CPT codes with global rates based on a 90-day period. We then reviewed the outpatient records and found that office visits and examinations that occurred within the 90-day period were counted as separate "billable" encounters and used to justify the established per diem rate for the contract. As a result, VA paid more for these services than private facilities that bill Medicare. In another review, the affiliate proposed procedure based payment for surgical procedures and a per diem rate for the clinic days. Because some percentage of the clinic visits is included in the global rate (e.g., pre- and post-operative visits), the proposed pricing using a mix of procedures and per diem would result in the Government paying the contractor twice for the same service.

4. The Medicare Part B National Physician Fee Schedule identifies the circumstances under which more than one physician can be paid for performing a procedure. In reviewing clinic data for one contract, we found instances where two residents, or a resident and an attending, both counted the office visit and the procedures performed during that visit for the same patient, which is not allowable under Medicare Part B. The reported CPT codes were used by the affiliate to establish the estimated RVUs needed to meet the requirements of the contract. As a result, VA's requirements were overstated, which resulted in inflated prices.

5. Regulations issued by the Department of Health and Human Services establish requirements for the participation of the attending physician in procedures and examinations to qualify for payment under Medicare Part B. For example, 42 CFR § 415.17 provides that services furnished in teaching settings are payable under the physician fee schedule if the services are personally furnished by a physician who is not a resident, or furnished by a resident in the presence of a teaching physician, except as provided in §§ 415.172, 415.174, 415.176, and 415.184. The regulations also contain specific documentation requirements to qualify for payment. We have not seen any evidence in our reviews to show that these regulations were applied to, or even

considered for, VA contracts and proposals with an affiliate or fee basis agreement where Medicare rates are used to establish pricing, or as a comparison in determining price reasonableness. In each case, the VA medical center and/or the affiliate count each patient interaction without regard to the presence and/or participation of the attending physician whose services are being procured under the contract.

In a post-award review, we analyzed operating room logs to identify the procedures where the attending physician was present at the procedure as the surgeon or as the first or second assistant. From the standpoint of the attending physician's entitlement to payment, we found no documentation of the presence of an attending physician during surgical procedures for more than 53 percent of the procedures or, from the clinic records, the presence of an attending physician for more than 90 percent of the patient encounters in the outpatient clinics. According to Medicare regulations, the attending physician would not be entitled to Medicare Part B payment for the services provided by a resident without the attending physician present during the examination/procedure. In this case, the VA solicitation was FTE based. In its proposal, the affiliate established per diem pricing based on its workload, which the affiliate then converted to surgical and clinic days. The surgery logs, which included a CPT code for each procedure, and the list of outpatient encounters, which identified the provider, the patient, and the CPT codes describing each outpatient encounter, were used to establish the per diem rates. Medicare Part A and Part B rates for the anticipated workload were used to show that VA was paying less under the contract than if the patients had been sent to the affiliate or other provider for treatment. The statement of work in this contract did not distinguish between the services provided by the contract physicians and the residents, who were being paid under a separate agreement. Examples from the Description of Work section of the contract are, "Patients being provided . . . will be evaluated by a contract otolaryngologist, Resident or mid-level provider." and "The contract otolaryngologist or Residents shall insure consultative services are made available within 24 hours of the request . . ."

Other Concerns About Procedure Based Contracts

In addition to concerns about overpaying for the services being provided, we have questioned whether strict procedure based contracts for services to be provided at VA medical centers are appropriate and have recommended that contracts with affiliates for services to be provided at VA be FTE based. The following are some of the concerns we have raised in pre-award reviews and in discussions with medical center personnel and the OGC:

- We have reviewed data from 25 of VA's 107 affiliated medical schools. Our pre-award and other reviews that evaluated salary and benefits costs for contracts with affiliates have included a review of contracts and other payment arrangements between the affiliate and/or the physician practice group and the individual

providers expected to provide services under the contract. This has shown that physicians are paid annual salaries which, in some cases, are based on their appointments as a full Professor, Associate Professor, Assistant Professor, etc. This shows that it is not a commercial practice to hire and pay medical staff on a per-procedure basis, which is inconsistent with how the affiliates expect VA to pay under these contracts. Our research shows that per-procedure rates have been established as a method for billing third parties for care provided.

- In the procedure based proposals and contracts that we have reviewed, VA has not required the provider to be present or available for specific time periods during the day or week in case there are procedures to be performed or patients to be evaluated in clinics. Accordingly, patient needs may not be met. If the solicitation or contract establishes set hours with estimated quantities of necessary procedures, VA could be expected to pay for a specific number of procedures or patient encounters that may not have occurred, which would defeat the anticipated cost savings that the medical center hoped to achieve by using a per-procedure based contract.
- We conducted a post-award review of a contract in which prices were established on a per diem basis using anticipated surgical and clinic visits. The solicitation contained requirements for clinic and surgical days, but the affiliate added a clause, which VA accepted, stating: “The hours for all clinics and surgical services are estimates only. Contractor and its contract physicians shall be free to perform other services unrelated to this Contract at any given location during the scheduled clinic and surgical service hours once all scheduled activities have been performed and this non-Contract performance shall have no impact upon the Contractor’s entitlement to payment under this Contract. This contract is not based upon hours of attendance or service performance but rather is based on expected RVU productivity.” As another example, we were advised by one VA medical facility that it entered into an indefinite quantity procedure based contract for services to be provided on an as needed basis. The contract contained an estimated number of procedures which was used to establish contract pricing. Because the procedures were expected to be done on an emergency basis, the contract required the providers to be available to perform the services within a short time after being contacted by VA. At the end of the contract term, the number of procedures actually performed was less than the estimated quantity, and the provider sought payment for the remaining amount. The provider’s argument was that because they had to make an individual available to VA, this individual could not be involved in procedures for other clients, which resulted in the loss of potential income.

- With one exception, the proposals and contracts we have reviewed for services to be provided at VA contained a requirement that the contract physicians participate in resident training and in VA administrative functions, such as quality assurance activities.¹⁹ These administrative duties were the basis for the recommendation that VA pay up to 150 percent of the Medicare rate for procedures. We disagree for several reasons. First, there is no basis for determining what percentage of the Medicare rate would be appropriate, because there is no relationship between individual procedures and the required administrative duties. Second, there is no justification for paying additional overhead or malpractice costs for services that are unrelated to these components of the Medicare rates. Third, unless there is a cost component associated with the administrative requirements, VA does not have a basis for withholding payment if the providers do not provide the services. We have recommended that solicitations detail the specific administrative duties the contract employees are expected to provide and determine the number of hours expected to be spent performing these duties. Payment for these duties should be negotiated as a separate line item. VA should monitor performance and withhold payment if the services are not provided.

Contracts for Services to Be Provided at the Affiliate

Since FY 2000, we have completed nine pre-award reviews and one post-award review for services to be performed at affiliated medical institutions. The contracts and proposals have been for transplants and related services and radiology procedures, such as outpatient radiation oncology. Our reviews have consistently raised the issue that VA is being overcharged. With regard to inpatient care provided at the affiliate to VA beneficiaries, Medicare Part A and Part B rates are used as benchmarks to determine pricing, or pricing is based on actual costs. For those contracts where outpatient care is provided to VA beneficiaries at the affiliate, Medicare Part B rates are used as a benchmark. Unlike contracts and proposals for services to be provided at VA, there seems to be reluctance on the part of affiliates to limit payment to Medicare rates.

Medicare Part A

Medicare Part A covers inpatient hospital costs. Facilities are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The costs are based on the Diagnostic Related Group (DRG) associated with the care provided and computed for the specific facility providing the care. According to Medicare regulations, the rate is based on an average length of stay and includes all hospital costs such as laboratory work, medication, nursing care, physical therapy, care

¹⁹ For the one contract that did not contain a resident or other teaching requirement, we questioned the need to obtain the services on a sole-source basis from the affiliate instead of competing the requirement.

provided by interns and residents, etc.²⁰ In the reviews we have conducted, Medicare Part A rates would have covered all costs except those associated with the care provided by attending physicians and others whose fees are covered by Medicare Part B and, in those contracts in which the procedure involves an organ transplant, the cost of the organ. VA should not pay the affiliate more than Medicare Part A would pay the affiliate for the same care. We also believe that there should be an offset for care provided at VA in the 3 days prior to admission to the affiliate and for any care provided by VA if the patient is transferred back to VA for care prior to discharge. This is necessary if the length of stay has not met or exceeded the average length of stay used by Medicare in establishing the rate.

According to CMS, the Medicare Part A rates are calculated for individual providers. Medicare's "Grouper" software identifies the appropriate DRG for the care to be provided, or procedure to be performed, and Medicare's "Pricer" software identifies the appropriate Medicare payment for the procedure(s) to be performed at that provider's facility. As noted above, Medicare Part A rates are based on an average length of stay. Therefore, except in certain circumstances, there is no offset if the patient is discharged before, or stays beyond, the average number of days on which payment has been calculated. What this means to providers is the opportunity to benefit from the Medicare Part A payment if the patient can be discharged earlier than the average number of days on which the payment is calculated. Some of the issues we have identified relating to Medicare Part A services include:

1. Although contract prices are based on Medicare Part A rates or Medicare Part A plus a percentage of Medicare Part A for the procedure, the contract provision requires that the patient will be transferred back to VA for continued care within a certain time period (e.g., 3, 7 or 15 days), with no offset. When the transfer occurs prior to the patient meeting or exceeding the average length of stay on which the Medicare Part A payment is based, the Government is paying twice for the same care in that VA is now taking care of the veteran and still paying the affiliate. For example, in 2004, the Medicare Part A rate for a heart transplant is based on an average length of stay of 40 days. If the affiliate transfers the patient back to VA prior to 40 days without the appropriate offset, the Government is paying twice for the care provided for at least the number of days the patient is treated at VA. The same is true if the patient is not transferred back to VA and the contract requires VA to pay additional fees on a per diem basis for days that exceed the number agreed to in the contract, but do not exceed the average number of days upon which the Medicare rate has been established.

²⁰ The inpatient operating costs used to determine the prospective payment are identified in 42 CFR § 412.2. These costs include: operating costs for routine services such as costs of room, board, and routine nursing services; operating costs for ancillary services such as radiology and laboratory services furnished to hospital inpatients; special care unit operating costs, malpractice insurance costs, and preadmission services otherwise payable under Medicare Part B furnished during the 3 calendar days immediately preceding the date of admission to the hospital. This regulation also identifies specific costs that are excluded.

2. Contracts and proposals generally require all pre-operative evaluations be conducted by VA at the VA facility without consideration as to whether any of these costs are covered in the Medicare Part A rate that VA has agreed to pay the affiliate for performing the procedure. Medicare Part A rates include care provided 72 hours prior to surgery. If the patient is cared for by VA during this time period without an offset, the Government is paying twice for the care.

3. In some instances, the affiliate proposes that VA pay costs, or a percentage of costs, for the procedure instead of using the Medicare Part A rates. In one proposal for heart transplants, the affiliate proposed a flat rate for a 3-day stay, which included the day of surgery, and a per diem rate for each additional day the patient stayed, without regard to the level of care required on any given day. If the contract had been awarded at the proposed pricing structure and a patient remained an inpatient at the affiliate for 40 days, the proposed cost would have been \$224,600. The Medicare Part A rate for the same procedure for that medical facility for 2004 was \$138,906, which is far less than the rate proposed for VA.

4. Both the Medicare Part A rate and any negotiated daily rate include a cost for pharmaceuticals. Our reviews have shown that pharmaceutical costs can account for as much as 20 percent of the total contract price. Because VA can procure drugs at a much more reasonable cost and, according to VA's National Acquisition Center, can reimburse the affiliate in kind for many of the drugs needed for these procedures, we have recommended in our reports and in discussions that the pharmaceutical costs be excluded from any rate calculation and a clause included stating that VA will reimburse the affiliate in kind. As justification for not following this recommendation, one medical center raised the issue of having different drug formularies. This is not a valid issue for two reasons. First and foremost, most, if not all, of the drugs used in these procedures are innovator drugs that are required by statute to be on VA Federal Supply Schedules (FSS) at or below the Federal Ceiling Price (FCP). Therefore, VA can procure them through the pharmaceutical prime vendor. Second, for medications that the patient is expected to be on post-operatively, it is likely that the patient will be receiving the same medications once he or she is transferred back to VA for care prior to and after discharge from the hospital.

Another argument is that it would result in increased costs to the individual medical centers because transplant costs are paid out of a VA Central Office (VACO) fund and the amount paid is based on the negotiated contract price, which would not include pharmaceuticals that the medical centers would pay for directly to reimburse the affiliates in-kind. We spoke with the Director of the VA Transplant Program who stated that the program reimbursed the individual medical centers for the costs incurred by the medical center to have the procedures done at the affiliate, including pharmaceuticals. Although the negotiated contract prices were used by the Program Office to determine the amount that the VACO would reimburse individual medical centers, the Program Director was

not opposed to calculating reimbursements using the contract price plus the costs the medical center incurred directly to purchase the pharmaceuticals needed to reimburse the affiliates with “in-kind” pharmaceuticals.

We were also advised by some medical center personnel that the administrative effort involved would be too much to make this a feasible option. However, we were not provided any cost analysis to show that administrative costs incurred by VA to reimburse in kind would eliminate the anticipated cost savings, which should be significant. The following chart shows the price differences we found for a sample of drugs in a case where we were able to compare the prices VA was charged to the prices VA would pay for the same medication:

Drug	Price Charged Per Unit	FSS Price Per Unit	Percent Difference Paid
Hydrocodone 5 mg	\$ 4.42	\$0.98	351.0
Fluconazole	57.40	7.95	622.0
Potassium Cl.	4.46	2.58	72.9
Hydrocodone 7.5 mg	6.49	0.72	801.4
Milrinone	676.19	24.93	2612.4
Aprotinin	1017.14	56.45	1701.8

Medicare Part B

We believe that Medicare Part B rates can be relied on to negotiate payments for the services provided by physicians and other eligible providers at the affiliate. However, VA personnel need to ensure that these rates are adjusted for services provided at the VA, whether the services are provided by VA employees or contract providers being paid under a separate contract. As previously discussed, the Medicare Part B rates for some procedures are global in nature, in that they include the care expected to be provided in the immediate pre-operative and the post-operative period, sometimes up to 90 days. If a patient has a procedure at the affiliate and is transferred from the affiliate to VA for post-operative care, the Medicare Part B payment should be adjusted accordingly to ensure the Government is not paying twice for the same services.

Also, as discussed previously, Medicare Part B regulations establish specific requirements for the presence and participation of the attending physician during the procedure and during outpatient visits to be eligible for payment. However, none of the eight contracts/proposals that we reviewed for services to be provided at the affiliate contained like or similar requirements. The Medicare requirements for participation by the attending physician should be included in any contract for services to be provided at the affiliate. As an example, 42 CFR § 415.180 establishes the requirements for payment

in a teaching setting for the interpretation of diagnostic radiology and other diagnostic tests. The general rule is that the physician fee schedule payment is made if the interpretation is performed or reviewed by a physician other than a resident, and that the documentation must indicate that the physician personally performed the interpretation or reviewed the resident's interpretation with the resident. None of the proposals we reviewed for radiology services, whether performed at VA or the affiliate, cited this Medicare requirement.

Conclusion

The details of the issues presented above led us to the conclusion that improvements are needed in contract pricing issues as follows:

Recommended Improvement Action(s) 2. We recommend that the Acting Under Secretary for Health take action to:

- a. Require that contracts for services to be provided at the VA medical facility be FTE based unless there is an approval from the VISN based on written justification showing that a procedure based contract is in the best interests of the Government.
- b. Consider the use of Title 38 U.S.C. §7409 authority for sole-source contracts with the affiliate, and consider making the contracts cost-reimbursement, not firm-fixed price.
- c. Require all acquisition plans, when relevant, to document the justification for the number of FTE required under the contract.
- d. Require that the solicitation specify the percentage of time each FTE will spend in patient care and non-patient care activities, e.g., administrative duties, research, training, etc.
- e. Require that all FTE based proposals identify the key personnel who will provide the required services and the level of effort each physician is expected to provide.
- f. Require terms and conditions in the contract that prohibit the affiliate from changing key personnel without VA approval and, when changes in key personnel are approved, that contract prices will be adjusted accordingly to reflect the salary and benefits of the personnel providing the services.
- g. When multiple physicians are expected to provide services under the contract, compute annual, monthly, or hourly rates, depending on the statement of work or

other requirements in the solicitation for each physician identified as key personnel; require the affiliate and/or practice group to provide data showing the total number of hours each physician is required or expected to work annually; and use this information to negotiate contract prices.

- h. Establish a policy that delineates allowable overhead costs that is based on costs incurred by the affiliate that are allocable to the services being provided under the contract.
- i. Establish a policy specifying the expected on-call duty that VA physicians are expected to provide as part of their VA duties and responsibilities, and include the requirements in individual employment agreements.
- j. Establish a policy prohibiting the inclusion of additional costs for on-call duty unless it can be shown that the individual physicians receive supplementary compensation for on-call duty as part of their contractual agreements with the affiliate, and identify the circumstances, if any, in which it is appropriate for contract employees to have on-call responsibilities concurrently at VA, the affiliate, or other medical institution.
- k. Establish a policy discouraging profit to the affiliate on sole-source contracts.
- l. In those limited circumstances where a procedure based contract is deemed appropriate and necessary for services to be provided at VA, establish a policy requiring:
 - Medicare Part B rates will be the basis for pricing.
 - The overhead component of Medicare Part B rates will be excluded from the price paid.
 - In those circumstances where some payment for overhead is appropriate, overhead will be included as a separate line item and pricing will be based on actual costs incurred.
 - Contracts will be indefinite delivery, indefinite quantity.
 - Payments will be based on the actual procedures performed, not estimated procedures.
 - Contracts include provisions consistent with CMS regulations establishing the level of attending physician participation to be eligible for payment.
 - VA medical facilities to develop and maintain an information system that will provide accurate and complete information to evaluate the number and types of procedures and examinations performed to ensure VA does not pay for services included in a global rate or performed by someone other than the contract provider.

- Solicitations delineate specific administrative responsibilities and that prices for duties will be negotiated as a separate line item.
- VA medical centers to monitor performance and withhold payment if the administrative services are not provided.

m. Establish a policy for contracts for services to be provided at the affiliate that:

- Limits payments to Medicare Parts A and B rates, and adjust these rates to ensure VA is only paying for services provided at the affiliate.
- During contract negotiations, VA will consider reimbursing pharmaceuticals in-kind and deducting pharmaceutical costs from the Medicare Part A or other negotiated rate, unless an analysis of costs demonstrates that it would be cost neutral, not cost effective, or legally not allowable.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. Details of his response are shown in Appendix C, pages 70-83.

Office of Inspector General Comments:

The Acting Under Secretary for Health comments met the intent of the recommendations. We will continue to follow-up on all planned actions until all of the issues have been resolved.

Issue 3: Conflict of Interest and Other Legal Issues

Findings

OIG work has identified legal issues relating to VA's award of sole-source contracts with affiliates under the authority of 38 U.S.C. § 8153. These include: violations of conflict of interest laws, misuse of the §8153 authority, improper personal services contracts, contracting for inherently governmental functions, and liability issues.

Violations of Federal Conflict of Interest Laws

We have identified several situations where VA physicians, who also receive compensation from the affiliate and/or the affiliate's practice group, are involved in the contracting process in violation of Federal ethics laws and regulations.²¹ The most frequent violations are of 18 U.S.C. § 208, which prohibits employees of the Executive Branch from participating personally and substantially as a Government officer or employee in any matter in which he or she has a financial interest. Violations of §208 carry both criminal and civil penalties.²²

With respect to contracts with the affiliate or the affiliate's practice group, the most common activities that violate Government ethics laws that we have identified by VA employees who have a financial interest in the affiliate or the affiliate's practice group include:

- Submitting and/or approving a request for a contract.
- Developing contract specifications, including the statement of work.
- Determining the work to be performed under the contract.
- Negotiating contract terms and conditions, including pricing, with the affiliate.
- Acting as the Contracting Officer's Technical Representative.
- Evaluating contract performance.
- Providing services for compensation under the contract in addition to their VA duties and responsibilities.
- Receiving additional financial benefits, such as tuition, travel, license and professional membership fees, etc., from the affiliate or practice group.

The following are examples of ethics violations:

1. A VA Regional Counsel referred a case to the OIG after determining that a part-time VA service chief, who also held a paid appointment at the affiliate, violated Federal conflict of interest laws. The service chief had a major role for VA in the development of the statement of work and other contract provisions that directly affected the contract price, including the amount that the affiliate would pay him personally. Under the contract, the physician was to be hired by

²¹ The Federal ethics laws are codified in 18 U.S.C. §§ 203, 204, 205, 207, 208 and 209. The relevant regulations are contained in Part 2634 of Title 5, Code of Federal Regulations.

²² Criminal penalties for violations of 18 U.S.C. §§ 203, 204, 205, 207, 208 and 209 include fines, imprisonment, or both. See 18 U.S.C. § 216. In addition, §216 allows the Attorney General to bring a civil action against the individual with penalties up to \$50,000 for each offense.

the affiliate to provide services to VA, which essentially included the same services he provided while working for VA. The amount he would receive from the affiliate would represent a significantly higher salary. Regional Counsel determined that the physician's actions violated 18 U.S.C. §§207 and 208.

2. In another instance, we requested an opinion from the VA Designated Agency Ethics Officer (DAEO) in OGC when documentation showed that a service chief, who recommended a contract with the affiliate, was also employed by the affiliate and was expected to provide services to VA under the contract. The DAEO agreed with our concerns and issued an opinion which concluded that the request or recommendation for the contract violated 18 U.S.C. §208. He further determined that the physician's dual employment status at VA (i.e., VA and contract employee), also violated §208 because the physician was in a position to do less work during his VA tour, thereby increasing the amount of work needed to be performed under the contract, which would increase the value of the contract for the affiliate.

3. Another matter we referred to the DAEO involved a proposal for a nurse and technician for a specific medical specialty. Documentation showed that a VA Service Chief submitted the request to purchase the services of the nurse and technician from the affiliate and the Chief of Staff approved the request. We also established that both the Service Chief and the Chief of Staff had a financial interest in the affiliate. The DAEO agreed with our concerns and concluded that both the Service Chief and the Chief of Staff violated 18 U.S.C. §208. In addition, the solicitation provided only an estimate of the services needed under the agreement and stated that the Service Chief and/or the Chief of Staff would be the individuals responsible for determining the quantity of services to be provided under the contract. Because the quantity of services affecting the contract payment is a matter of the financial interest of the affiliate (their employer), the DAEO determined that any individual with a financial interest in the affiliate would violate 18 U.S.C. § 208 if they participated in decisions affecting the quantity of services to be provided under the contract.

4. Two cases that we referred to the DAEO involved contract solicitations for in-patient services to be provided at the affiliate. The first solicitation listed functions for the VA Medical Center Chief of Staff, who was employed part-time by the affiliate (and thus had a financial interest in the affiliate), that included: (i) approving stays in excess of 3 days, (ii) directing the services performed under the contract and reviewing personnel qualifications, (iii) approving re-admissions to the affiliate hospital, and (iv) making final determinations on the patients' transfers back to VA and verifying contract compliance. In the second solicitation, the Chief of Staff, who had a similar financial interest in the affiliate, was to be responsible for resolving disputes between VA and the affiliate for stays in excess of 7 days, and would be responsible for approving stays in excess of 15 days. In both cases, the DAEO advised that the functions called for in the respective solicitations would result in violations of 18 U.S.C. §208 because they would affect contract revenues for the affiliate contractors. These decisions were provided to both the contracting officer and Regional Counsel.

These are but a few examples of the conduct involving sharing agreements with affiliates that violate Federal conflict of interest laws and regulations. The conduct described is not new. A

decision issued by the VA Board of Contract Appeals in 1996 shows that conduct violating 18 U.S.C. §208 had been part of the contracting process at one facility for at least 14 years.

During pre-award reviews, we advise the contracting officer of any potential conflict of interest violations and recommend that they seek an opinion from VA's DAEO. We also have discussed conflict of interest issues at training sessions for VA contracting personnel that were sponsored by the OA&MM in FYs 2002, 2003, and 2004. Despite our advice and recommendations, by mid-FY 2003 only one contracting officer had contacted the DAEO. Because of our increasing concern that there were widespread violations of Federal ethics laws, we initiated referrals of potential ethics violations to the DAEO. In the past year, we have received five formal opinions from the DAEO and informal advice in three other matters. The opinions issued by the DAEO substantiated our concerns.

In response to reports by the General Accounting Office (GAO) and the OIG that some physician supervisors and managers stated that they did not know about the applicable conflict of interest laws, VHA issued VHA Handbook Chapter 1660.3, "Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services and Health Care Sharing" in 1993. This handbook has been revised several times, most recently on July 24, 2002.

VHA Handbook 1660.3 discusses 18 U.S.C. §208 and 5 C.F.R. 2635.402 in great detail. The handbook specifies permitted and prohibited activities relating to the negotiation, award, and administration of Scarce Medical Specialist and Health Care Sharing contracts. In addition, the handbook requires each facility Director to ensure that each Chief of Staff and each physician supervisor or manager receives a copy of the handbook and acknowledges receipt by signing an acknowledgement form that is required to be placed in the employee's Official Personnel Folder.

Based on our pre-award review findings and discussions with VHA personnel regarding Health Care Resource contracts, we concluded that there was a lack of awareness of VHA Handbook 1660.3 and of conflict of interest laws in general. In August 2003, during on-site reviews at 15 VA medical facilities, we requested documentation to show compliance with the requirement that the affected individuals were provided a copy of the handbook and that they signed an acknowledgment form that was placed in the individual's Official Personnel Folder. We found:

- Five facilities (33%) had 100 percent compliance.
- Six facilities (40%) had zero percent compliance.
- Two facilities distributed the policy, but had no signed forms.
- One facility distributed the policy, but only obtained 50 percent of the signatures.
- One facility distributed the policy, but only obtained 60 percent of the signatures.

Two of the 15 facilities involved in our August 2003 on-site review had previously submitted proposals for pre-award reviews in which we had identified possible conflict of interest violations and had recommended seeking opinions from the DAEO. One of these facilities had distributed the handbook, but only had 50 percent compliance with obtaining the required acknowledgment forms. Neither the Chief of Staff nor the service chief, both of whom had participated in the development of the solicitation and contract negotiations, had signed the

acknowledgement forms. The second of the two facilities was one of the two that had distributed the policy, but had not obtained any signed acknowledgement forms.

We recognize that there are inherent conflict of interest issues at VA facilities that contract with affiliates because a large number of VA physicians at those facilities have a financial interest with the affiliate, its practice group, or both. Enforcing compliance with VHA Handbook 1660.3 would avoid conflict of interest violations. Violations of Federal conflict of interest laws and regulations can be avoided by having an entity other than the affected medical center prepare, negotiate and award these contracts. This could be done by having the process centralized at the VHA Veterans Integrated Service Network (VISN) level, as is the policy in VISN 16.

VHA and OGC should provide mandatory training on conflict of interest laws and regulations and their applicability to all Title 38 employees who have relationships with the affiliate. VHA also should develop and implement a policy that centralizes contracting activities with affiliates at the VISN level, and prohibits local VA facilities from contracting with their affiliates directly.

Misuse of §8153 Contracting Authority

Section 8153 authorizes the Secretary to enter into contracts or other agreements “...to secure health-care resources which otherwise might not be feasibly available.” For services, the section permits the use of sole-source contracts or agreements to acquire commercial services from an institution affiliated with VA. A commercial service is defined as a service that is bought and sold competitively in the commercial marketplace, is performed under standard commercial terms and conditions, and is procured using firm-fixed price contracts. The following are examples where VA facilities are using the §8153 sole-source authority inappropriately by:

- Purchasing services of residents or other physicians in training.
- Purchasing services of a locum tenens physician.
- Participating in the affiliate’s work-study program.
- Purchasing staff required to conduct administrative reviews to establish a statement of work for a future or follow-on contract.
- Purchasing services that can be acquired more cost-effectively by VA employees.
- Purchasing services for positions that currently are encumbered by VA personnel.
- Purchasing consulting services.

1. We reviewed a solicitation whose requirements included the services of a “fellow.” A fellow is a physician who has completed an internship and residency training program, but is continuing training in a subspecialty. An example is a surgeon who has completed his residency training in general surgery, but is completing a fellowship in plastic surgery. OGC advised us that the individual’s services could be procured under the contract if the individual was appointed to work as an attending physician in the area in which he was board certified or board eligible. However, contracting for the physician to work in the area in which he is still in training would be outside the scope of the intent of §8153. The services of individuals who are in training do not qualify as a “commercial service” as defined in §8153. Based on our recommendation, the VA medical center amended the solicitation to omit the services of a fellow.

2. A proposal included payment for medical services that were to be provided by a physician who was not an employee of the affiliate or the practice group. Rather, the individual was an employee of a private contractor that the affiliate contracted with for the sole purpose of obtaining physician coverage for VA while the affiliate recruited for a replacement for a physician who had recently left. The affiliate stated that it was “even considering [the physician] for a permanent appointment pending further observation of his performance and interviews with [its] other physicians.” In other words, if the physician’s care and treatment of veterans was acceptable to the practice group, he might be allowed to treat patients at the affiliate. Furthermore, there was no evidence that VA could not hire directly for this position, that VA could not hire a locum tenens physician at a cost equal to or less than VA would be paying the affiliate, or that the contract was otherwise cost-effective and in the best interest of the Government. Also, the contract provided that the affiliate would provide medical malpractice insurance, worker’s compensation, unemployment, etc. Because the physician expected to provide services under the contract was not an employee of the affiliate, the affiliate could not meet these contract requirements.

3. The statement of work in a solicitation for radiology services required the affiliate to conduct a review of VA’s workload for the purpose of preparing a statement of work for a follow-on contract in which payment would be procedure based. The contracted services were to be performed at the affiliate and by administrative staff who were not involved in patient care. In addition to the fact that the services to be provided were outside the scope of the health care resources as defined in 38 U.S.C. §8152, we also considered it to be a conflict of interest for the affiliate to conduct the study that would be used as the basis for the statement of work in a subsequent solicitation for a contract to be awarded on a sole-source basis to the same affiliate. Based on our recommendation, the requirement was removed from the solicitation.

4. A solicitation contained requirements for the services of physical therapists. When we questioned whether physical therapists were not otherwise available to VA through direct hire, we were told that VA could hire them directly and at a lower cost. However, VA wanted to purchase the services through a contract because the affiliate’s program had a good reputation. In addition to not being cost-effective, the procurement of these services through a sole-source contract with the affiliate was inconsistent with the basic premise of §8153, which is: “To secure health-care resources which otherwise might not be feasibly available, or to effectively utilize certain other health-care resources.” The solicitation was also inconsistent with VHA Directive 97-015, Sections 4.b (1) and (4), which requires the contract to be cost-effective and in the best interests of the Government. Although we raised these concerns during a pre-award review of the first contract, no changes were made. We raised the same concern in the pre-award of the follow-on contract, and the VISN required the cancellation of the solicitation.

5. A solicitation issued by a VA medical center contained a requirement for secretarial services, which the medical center explained was a GS-5 Program Support Clerk position to support the outpatient clinics.²³ We were told that the position was not currently vacant but that there was a hiring freeze. Therefore, if the incumbent left, they would not be able to fill the position and the workload could not be delegated to other staff. We contacted personnel in Human Resources and were advised that the hiring freeze would not preclude the hiring of a Program Support Clerk

²³ The requirement was included at the insistence of the affiliate.

if the position was necessary. We then were advised by the affiliate and the VA medical center, that the requirement was still needed because if the position became vacant, it would take longer for VA to fill the position than it would for the affiliate to provide the services via the contract. We also spoke with OGC and were advised that the requirement may violate the provisions of OMB Circular A-76. We concluded that there was no valid justification for procuring the resource sole-source from the affiliate because there was insufficient evidence that the resource was not feasibly available as required by §8153. We also recommended that the facility refer the matter to OGC for an opinion.

6. A proposal included payment to the affiliate for the purpose of providing benefits to VA physicians who were not expected to provide services under the contract. The benefits included fees for licensures and memberships in professional organizations and an education benefit for professional development. This was not an appropriate use of §8153 authority and may have resulted in a violation of 18 U.S.C. §209, which prohibits illegal supplementation of salary.

7. During a CAP review, we identified a physician who was hired under two separate contracts to provide radiology services at two VA medical centers. Under one contract, the physician was to provide the services of 0.5 FTE as the Chief of Radiology Service and that he would “be available” to provide services for no less than 20 hours per week. Approximately 6 months after award, the contract was modified and the new duties were “consultative imaging services.” Section 8153 is not the appropriate authority for obtaining consultative services. During the same time period, the physician was hired through a contract with the same affiliate and a VA medical center, located 200 miles away, to provide 0.625 FTE services as the Chief, Radiology Service. Although the contract did not specify a specific tour of duty, the terms of the agreement required the physician to be present Monday through Friday. We question whether it would be physically possible for the same physician to provide 1.125 FTE of services on a weekly basis in facilities that are hundreds of miles apart.

Prohibited Personal Services Contracts

A personal service contracts is defined in FAR 37.101 as “...a contract that by its express terms or as administered makes the contractor personnel appear, in effect, Government employees.”²⁴ FAR 37.104 prohibits agencies from entering into personal services contracts unless specifically authorized by statute. Neither §8153 nor §7409 specifically authorizes VA to enter into personal services contracts to obtain health care resources. Accordingly, VHA and OGC have determined that contracts awarded pursuant to §8153 or §7409 cannot be for personal services.²⁵

Under non-personal services contracts, the personnel rendering the services are not subject by the contract’s terms or by the manner in its administration, to the supervision and control usually

²⁴ See also, *Matter of: Nuclear Regulatory Commission Licensing Examiners*, 70 Comp.Gen. 682, (1991) (A personal services contract is a contract that by its express terms or by the way in which it is administered makes it appear that the contractor personnel are federal employees.)

²⁵ The Secretary does have authority to enter into contracts for personal services under 38 U.S.C. §513, which provides: “The Secretary may, for purposes of all laws administered by the Department, accept uncompensated services, and enter into contracts or agreements with private or public agencies or persons. . . , for such necessary services (including personal services) as the Secretary may consider practicable.”

prevailing in relationships between the Government and its employees. FAR 37.104(d) identifies six factors that provide guidance in determining whether a services contract is personal in nature:

- Performance is on site.
- Principal tools and equipment are furnished by the Government.
- Services are applied directly to an integral effort of the agency, or an organizational subpart, in furtherance of the mission.
- Comparable services meeting comparable needs are performed in the same agency using civilian personnel.
- The need for the service provided can reasonably be expected to last more than 1 year.
- The inherent nature of the service or the manner in which it is provided reasonably requires, directly or indirectly, Government direction or supervision of contractor employees in order to (1) adequately protect the Government's interests; (2) retain control of the function involved; or (3) retain full personal responsibility for the function supported in a duly authorized Federal officer or employee.

A "yes" to one or more of these factors should raise the question whether the solicitation will result in a prohibited personal services contract. All of the solicitations that we reviewed which were issued pursuant to §8153 authority for services to be provided at VA facilities met the first five factors in these guidelines. An analysis of the statement of work and the administration of the contracts shows that they also met the sixth factor. Although all of the factors are not required for a contract to be considered an improper personal services contract, OGC has concluded that the key issue in these cases is whether the Government will "...exercise relatively continuous supervision and control over the contractor personnel performing the contract."

We referred a solicitation to OGC for an opinion whether the contract, if awarded, would be a prohibited personal services contract. The solicitation required the services of a nurse practitioner and a technician for the Cardiology Service who would be under the supervision of the chief of the service. The solicitation further stated that services provided would be under the "direction of the VA Chief of Staff and the Chief, Cardiology Service." OGC agreed that an award would result in a prohibited personal services contract.

To avoid the personal services prohibition, the OGC opinion advised that the contract must state that the "Government may evaluate the quality of professional and administrative services provided, but retains no control over the medical, professional aspects of the services rendered (e.g., professional judgments, diagnosis for a specific medical treatment)," and cited FAR 37.401 (b) as the regulatory authority. After reviewing FAR 37.401, we concluded that the language cited by OGC was not required for contracts awarded under §8153 authority. The FAR provision cited by OGC specifically relates to contracts awarded under the authority of 10 U.S.C. §2304 and 41 U.S.C. §253.²⁶ OGC further advised: "to be consistent with the FAR the solicitation should provide that the nurse practitioner and pacer technician will be under only the administrative direction of the Cardiology Chief, and state expressly that they will not be under his medical or professional supervision."

²⁶ FAR 37.401 states: "Agencies may enter into non-personal health care services contracts with physicians, dentists, and other health care providers under authority of 10 U.S.C. §2304 and 41 U.S.C. §253."

OGC noted in the opinion that the typical language recommended in these agreements includes the term “under the direction of” a VA employee, in lieu of “under the supervision of” a VA employee. To explain the distinction OGC stated: “Supervision implies a superior-subordinate relationship, and a continuous oversight of the professional services provided. Whereas, “direction” implies that the contractor will be told what to do, as opposed to how to do it.”

Notwithstanding whether FAR 37.401 is applicable to §8153 contracts, based on our review of the FAR and our discussions with VHA personnel, we have concluded that merely using the correct verbiage in the contract document does not alter the fact that these are personal services contracts because contract employees are supervising VA employees. FAR 37.101 defines a “non-personal services contract” as:

“[A] contract under which the personnel rendering the services are not subject, either by the contract’s terms *or by the manner of its administration*, to the supervision and control usually prevailing in relationships between the Government and its employees. (Emphasis added.)

The regulation makes it clear that the words used in the contract are not the only determinant of whether the contract is a personal or non-personal services contract; the manner in which the contract is administered is equally important.²⁷ Merely changing words without changing the relationship between VA and the contract employees does not resolve the issue of whether these are personal services contracts.

When asked, VA medical center personnel have been unable to explain to us the difference between the words “direction” and “supervision”, as they impact on the relationship between VA and contract personnel. Responses ranged from (1) there was no difference between the terms, to (2) the distinction that VA could not terminate the contract employee’s employment if it provided direction, not supervision. We do not believe that this latter distinction is sufficient to render these contracts non-personal services contracts.

Although VA cannot terminate the contractor’s employment with the affiliate, VHA Handbook 1100.19, “Credentialing and Privileging,” issued on March 6, 2001, requires VA medical centers to credential and privilege all contract physicians. For quality assurance and reprivileging purposes, performance of contract employees is monitored through VA’s quality assurance programs, in which contract employees are required to participate, and VA has the authority, and a duty, to reduce or revoke privileges and report such changes to state licensing boards and the National Practitioner Data Bank.

In addition to FAR 37.104(d), VAAR 837.104 provides: “Personal service contracts having an employer-employee relationship shall not be awarded but will be consummated in accordance with VA Manual MP-5, Parts I and II. VAAR 837.104(b)(1)-(5) also provides additional

²⁷ See also, FAR 37.104 (c)(1), which states: “An employer-employee relationship under a services contract occurs when, as a result of (i) the contract’s terms and conditions or (ii) the manner of its administration during performance, contractor personnel are subject to the relatively continuous supervision and control of a Government officer or employee.”

relevant considerations for determining whether there is an employee-employer relationship that would make the contract a prohibited personal services contract:

- The contract does not call for an end-product, which is adequately described in the contract.
- The contract price or fee is based on the time actually worked rather than results to be accomplished.
- Office space, equipment, and supplies for contract performance are furnished by VA.
- Contract personnel are used interchangeably with VA personnel to perform the same function.
- VA retains the right to control and direct the means and methods by which the contractor personnel accomplish the work.

All five considerations are applicable to the solicitations we have reviewed for services to be provided at VA with the exception of those for which payment is strictly procedure based. For strictly procedure based contracts, the contract price or fee is not based on time actually worked.

VAAR 837.403 requires the contracting officer to insert an “Indemnification and Medical Liability Insurance” clause in all non-personal health care services contracts. The clause states, in part:

“The Government may evaluate the quality of professional and administrative services provided but retains no control over professional aspects of the services rendered, including by example, the Contractor’s or its health-care providers’ professional medical judgment, diagnosis, or specific medical treatments.”

Other factors, either individually or combined, that lead us to conclude that these are personal services contracts include:

- The providers are not identified to the patients or to other VA personnel as contract employees and are not required to identify themselves as contract employees in VA medical records. The fact that VA and contract employees are performing the same functions side-by-side in VA medical centers further blurs any distinction.
- Differentiating between VA employees and contract employees is more difficult when the individuals providing the services are working part-time as VA employees and part-time as contract employees performing the same job duties for the same patient population. VA personnel have told us that these dual employees are identified by their VA credentials at all times.
- We have been told by OGC and Assistant United States Attorney Offices that ambiguity in the status of these providers has led to confusion in the processing of claims filed pursuant to the provisions of the Federal Tort Claims Act.
- The contracts require that the services performed by the contractor will be performed in accordance with VA policies, procedures, and the regulations of the medical staff by-

laws of the VA facility. To ensure quality patient care is provided in VA facilities, VA must be responsible for the supervision, direction, and oversight of the contractor to ensure compliance.

- Contracts routinely contain a requirement that contract employees participate in VA administrative activities, as do VA employees, some of which are performing the same duties and responsibilities. For example, one proposal provided that the contract employees would “monitor and advise in the development of quality control equipment or in evaluations of current quality control protocols” and “membership on Ad Hoc or departmental or medical center committees as necessary.” There is no distinction between the roles of a contract employee and a VA employee in performing these duties.
- VA, not the contractor, makes decisions regarding whether patients are eligible for treatment and, in some circumstances, VA controls what treatment can be provided. The contractor does not have authority to deny treatment or authorize treatment beyond what VA determines the patient is eligible to receive. Patient complaints regarding treatment received by a contract employee are addressed by VA, not the contractor, and VA can take corrective action.

We believe that the provisions in these solicitations that make them personal services contracts, as described above, are necessary to ensure that VA provides quality patient care to veterans. We also believe that, because the Government is at risk for liability for services provided under these contracts, it is in the best interests of the taxpayer for VA to maintain supervision and control over the services provided under these contracts. As such, we recommend that VA review the provision of 38 U.S.C. §513 to determine whether VA has authority to enter into personal services contracts awarded to affiliates pursuant to the sole-source authority in §8153 and §7409. If §513 is not a viable option, VA should seek a legislative amendment to 38 U.S.C. §§8153 and 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.²⁸

Inherently Governmental Functions

OMB has established executive policy relating to service contracting and inherently governmental functions to assist Executive Branch officers and employees to avoid the unacceptable transfer of official responsibility to Government contractors. Prior to May 23, 2003, this policy was contained in Office of Federal Procurement Policy (OFPP) Policy Letter 92 -1. On May 23, 2003, revised OMB Circular A-76, “Performance of Commercial Activities,” was issued and superceded Policy Letter 92-1. The solicitations we have reviewed both pre-date and post-date revised OMB Circular A-76.

OMB Policy Letter 92-1 and OMB Circular A-76 both define an inherently governmental function as “...a function that is so intimately related to the public interest as to mandate performance by Government employees.” OMB Policy Letter 92-1 stated that it applied to non-

²⁸ Such authority would not be unprecedented. The Secretary of Defense and the Secretary of Homeland Security have authority to enter into personal services contracts to carry out health care responsibilities in their medical treatment facilities. See, 10 U.S.C. § 1091.

personal services contracts. Personal services contracts that are really personnel appointments were excluded from coverage of the policy letter. Neither personal services nor non-personal services contracts are addressed in the revised OMB Circular A-76. Appendix A of the Policy Letter 92-1 contained an illustrative list of functions considered to be inherently governmental functions. The list is not included in OMB Circular A-76, which provides that “inherently governmental activities require the exercise of discretion” and “...that the use of discretion shall be deemed inherently governmental if it commits the Government to a course of action when two or more courses of action exist and decision making is not already limited or guided by existing policies, procedures directions, orders, and other guidance that (1) identify specified ranges of acceptable decisions or conduct and (2) subject the discretionary authority to final approval or regular oversight by agency officials.”

In reviewing contract solicitations, we have identified contract requirements that appear to be inherently governmental functions. Our concerns include the direction and supervision of VA employees and involvement at the same level of participation as other VA employees in VA operations, such as quality assurance activities and VA committees. Contract providers also have broad discretion in making decisions relating to the care and treatment of veterans that result in expenditures of VA resources. For example, the following extracts are from the contract requirements in a solicitation issued by the VA Medical Center, Miami, Florida, to the affiliate for anesthesia services:

- For Pain Management Services - “The anesthesiologist directs and coordinates the intensive pain rehabilitation and pain management program. He/she will serve as chairperson of the Pain Management Committee and as a member of the Hospice Committee, the Tumor Board team and the Operative and Invasive Procedures Committee.”
- For the Surgical Intensive Care Unit:
 - “The anesthesiologist directs and coordinates the Surgical Intensive Care Unit and functions as the Unit Director.”
 - “The anesthesiologist designated as the Unit Director will insure that all administrative requirements related to Medical Center policies and procedures and JCAHO standards are implemented.”
 - “The anesthesiologist will participate as assigned to Medical Center Committees and task forces.”
- “All services include the following clinical tasks or other duties as assigned by VA but are not limited to:²⁹
 - Direction and assistance support of CRNAs, anesthesia assistants, staff anesthesiologists and other anesthesia service personnel.³⁰
 - Educational training and supervision of residents, medical students and CRNAs.

²⁹ The fact that the duties and responsibilities can be assigned by VA also raises the issue of whether this is an improper personal services contract.

³⁰ These individuals are VA, not contractor employees.

- Participation in service specific and Medical Center quality improvement programs and activities. This may include monitors for appropriateness, length of stay, incident reports, review of resident supervision, outcome measurements, access to levels of anesthesia care, patient satisfaction, effectiveness post-procedure pain control, reporting of adverse events.”
- “All services include the following administrative tasks and other duties as assigned by VA but are not limited to:
 - Review and approve the regular weekday operating room schedule.
 - Make daily operating room assignments and other duty assignments for all anesthesiology service staff recognizing their scopes of practice and level of responsibility.
 - All anesthesia services are to be performed either by the contract physician or with the contract physician providing professional direction to VA anesthesia CRNA staff or to the house staff at levels 1 and 2.”

This solicitation was one of the most comprehensive that we have reviewed and was written to ensure quality patient care. Nonetheless, the duties and responsibilities described above are inherently governmental functions and clearly make it an improper personal services contract. The contract anesthesiologists not only participate in, but even chair, VA committees, and there is no differentiation between the duties, responsibilities, and level of participation by VA employees on these committees and the contract employees. Providing direction/supervision to the CRNAs and other VA employees is an inherently governmental function.³¹

As another example, in the contracts described previously, in which the two VA medical centers contracted for the same physician to provide services in their facility as the Chief of Radiology Service, the statements of work in both contracts³² required the contract employee to exercise full line authority and responsibility for the management of the service, report to the Chief of Staff, and provide professional supervision of radiology physicians and supervisors of technical and administrative sections. Clearly, these contracts were personal services contracts, and these requirements were inherently governmental functions.

We also question whether providing direction/supervision to residents and medical students, who technically are not Government employees but for whose actions the Government accepts liability and responsibility, would also constitute an inherently governmental function.

Contract physicians providing services in VA medical centers have broad discretion in making decisions regarding patient care. For example, these physicians write orders for medications, x-rays, other diagnostic and surgical procedures, and follow-up care, etc. that are provided at the Government’s expense. In addition, they request equipment and supplies that VA must provide.

³¹ OFPP Policy Letter 92-1, Appendix A, paragraph 7.

³² Although the contracts were awarded by two VA medical centers, the requirements and other specific terms and conditions were identical.

OMB's Policy Letter 92-1, paragraph 3, prohibiting contracting for inherently governmental functions did not apply to services obtained by personnel appointments or advisory committees. Revised OMB Circular A-76 does not address this issue specifically. However, assuming the same is true under OMB Circular A-76, legislative changes to §§8153 and 7409 to permit these contracts to be personal service contracts would alleviate concerns about contract duties and responsibilities that are necessary to provide quality patient care, but are inherently governmental functions that cannot be obtained under contract.

Liability Issues

VAAR 837.403 requires the contracting officer to insert an "Indemnification and Medical Liability Insurance" clause in all non-personal health-care services contracts, which requires the contractor to provide and maintain professional liability insurance for the employees providing services under the contract. The contractor is also responsible for providing worker's compensation, unemployment and other similar benefits.

In FY 2003 and the first quarter of FY 2004, we reviewed 19 proposals, valued at \$32,301,512, for services to be provided at VA in which prices were determined on an FTE basis. Of this amount, \$1,063,588 (3.3 percent) was related to medical malpractice insurance.³³ During this same time period, we reviewed 12 procedure based proposals, only 5 of which identified a contract value for medical malpractice insurance. The value of the five proposals was \$15.2 million. Approximately 7 percent of the average RVUs assigned to physician costs under Medicare Part B relate to the medical malpractice component.

Although the contract provision requiring the contractor to provide medical malpractice coverage is intended to protect the Government from liability claims relating to services provided under the contract, we have identified three concerns. The first is whether the provider can be readily identified as a contract employee, particularly when the provider is caring for patients as both a VA employee and a contract employee. Our second concern relates to the liability in tort claims when the acts or omissions of a medical student, resident, or fellow is at issue, and that individual is under the direct supervision of a contract employee. Third, because care and treatment provided at a VA medical center often involves interactions between the patient and various health care personnel, it may be difficult for liability purposes to separate the acts or omissions of a contract provider and a VA employee.

As previously discussed, there is no clear distinction between VA and contract employees in their practice at VA. By comparing the physicians who may be expected to provide services under the contract with VA's payroll system, we have determined that some portion of the services, if not all, are expected to be provided by physicians who are also providing the same clinical services as part-time VA employees. In the event a patient

³³ The medical malpractice component of the proposals ranged from 0 percent to 11.07 percent.

suffers an adverse outcome as the result of treatment received at VA, unless it can be established that a single act of negligence occurring at a specific time was responsible for the patient's injuries and that the responsible physician was, at the time the negligence occurred, performing his duties as a VA employee or as a contract employee, it will be difficult for the Government to offer a defense that it is not the responsible party under the Federal Tort Claims Act. OGC informed us that VA and the Department of Justice have processed claims filed under the Federal Tort Claims Act, without a determination that the provider, whose care was at issue, was a contract employee. OGC also informed us that they were unaware of any cases in which liability in a tort claim was determined to be strictly that of the affiliate contractor and that it would be unlikely that VA would not be a party to an action when the care is provided at VA.

The Government accepts liability for the acts or omissions of medical students, residents, and fellows who provide care to veterans as part of an accredited training program with a VA affiliate. Although these individuals are not VA employees, the Government accepts liability because they provided care under the supervision of a VA employee when the alleged act or omission occurred. Under §8153 contracts, contract employees provide direct supervision for medical students, residents, and fellows who are part of the affiliate's medical training program. Yet, we have not seen any contract under which the affiliate is responsible for negligence by a medical student, resident, or fellow under the supervision of a contract employee. Our concern regarding increased liability for the Government is intensified by the fact that the alleged act or omission that resulted in harm may have occurred because of inadequate or non-existent supervision. It will be difficult for the Government to claim that the liability rests with the contract employee unless it can be shown that the contract employee was directly involved in the act or omission at issue. Even assuming the Government prevails in showing that the liability rests with the contractor, the Government still would have incurred significant litigation costs.

With a legislative change permitting personal services contracts for those awarded under the authority of §7409 and §8153, VA could accept the risk of liability for these contract providers, since the individuals would be considered to be Government employees. As such, VA would no longer have to pay for medical malpractice coverage, which would result in a significant cost savings to the Government.

Conclusion

The details of the issues presented above led us to the conclusion that improvements are needed in conflict of interest and other legal issues as follows:

Recommended Improvement Action(s) 3. We recommend that the Acting Under Secretary for Health take the following actions:

- a. Provide mandatory training on conflict of interest laws and regulations and their applicability to all Title 38 employees who have a relationship with affiliates.
- b. Develop and implement a policy that centralizes contracting activities with affiliates at the VISN level and prohibits local VA facilities from contracting with their affiliates.
- c. Work with OGC and, if necessary obtain an opinion from the Office of Legal Counsel at the Department of Justice, to determine whether the Secretary has authority under 38 U.S.C. §513 to enter into personal services contracts awarded to affiliates pursuant to the sole-source authority in §8153 and §7409. If §513 is not a viable option, we recommend that VA seek a legislative amendment to 38 U.S.C. §8153 and 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.
- d. Take action to enforce the provisions of VHA Handbook 1660.3, requiring the Director of each medical center to ensure that each Chief of Staff and each physician supervisor or manager receive a copy of the handbook and acknowledge receipt by signing the acknowledgment form and have it placed in the individual's Official Personnel Folder.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. Details of his response are shown in Appendix C, pages 70-83.

Office of Inspector General Comments:

The Acting Under Secretary for Health comments met the intent of the recommendations. We will continue to follow-up on all planned actions until all of the issues have been resolved.

Pre-Award Reviews for Sole-Source Contracts with Affiliates

FY 2000

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Pittsburgh	University of Pittsburgh Physicians	Cardiac Surgeon	1/14/2000	\$334,945	\$334,945	
Augusta	Med College of Georgia	Surgical	3/27/2000	-0-	-0-	
Pittsburgh	University of Pittsburgh Physicians	Anesthesiology	5/31/2000	297,833	297,833	
Houston	Baylor College of Medicine	Radiology	7/31/2000	179,777	179,777	
Pittsburgh	University of Pittsburgh Medical Center	Primary Care at Outpatient Clinic	9/7/2000	21,600	21,600	

FY 2001

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Philadelphia	University of Pennsylvania	Radiology	10/6/2000	3,198	3,198	
Little Rock	University of Arkansas	Anesthesiology	11/16/2000	413,704	225,303	
Indianapolis	Indiana University	Cardiovascular Surgery	2/23/2001	158,796	92,130	
Indianapolis	Indiana Pathology Institute	Pathology	2/23/2001	-0-	-0-	
Minneapolis	University of Minnesota Physicians	Radiology	3/29/2001	248,894	107,138	

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2001 (Cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Minneapolis	University of Minnesota Physicians	Chief of Radiology	4/11/2001	\$101,989	\$101,989	
Little Rock	University of Arkansas	Nuclear Medicine	6/20/2001	335,160	335,160	
Little Rock	University of Arkansas	Radiology	6/21/2001	760,347	760,347	
Miami	University of Miami	Anesthesiologist	8/23/2001	395,040	395,040	

FY 2002

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Palo Alto	Stanford University	Vascular	10/3/2001	174,181	174,181	
Palo Alto	Stanford University	Anesthesiologist	10/3/2001	554,705	554,705	
Columbia	University of Missouri	Imaging Services	1/30/2002	829,403	754,756	
Columbia	University of Missouri	Vascular Surgery	1/30/2002	98,834	42,465	
Columbia	University of Missouri	General Surgery	1/31/2002	64,902	64,902	
Pittsburgh	University of Pittsburgh Physicians	Thoracic Surgeon	3/6/2002	244,869	78,937	

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2002 (Cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Seattle	University of Washington	Anesthesiology	5/1/2002	\$869,558	\$869,558	
San Francisco	University of California	Anesthesiology	5/1/2002	25,034	25,034	
Omaha	University Medical Associates	Nephrology	8/15/2002	261,109	261,109	

FY 2003

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Palo Alto	Stanford University	Oral Surgeon	11/4/2002	-0-	-0-	
Cincinnati	University of Cincinnati	Outsourced Imaging Services	11/6/2002	-0-	-0-	Yes
San Francisco	University of California, San Francisco	Radiology	11/6/2002	509	509	
Cincinnati	University Radiology Associates	Radiation Therapy (Oncology)	11/7/2002	-0-	-0-	
Palo Alto	Stanford University	Chief of Surgery & Cardiothoracic Surgeon	11/7/2002	749,863	359,596	
Salt Lake City	University of Utah	Anesthesiology	11/20/2002	418,552	N/A	
Palo Alto	Stanford University	Neurosurgeon	12/2/2002	315,878	159,969	

N/A – Not awarded as of October 15, 2004

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2003 (Cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Cincinnati	University of Cincinnati	On-Site Imaging Services	12/2/2002	\$1,436,441	\$1,436,441	
Milwaukee	Medical School of Wisconsin	Radiology Services	1/15/2003	-0-	-0-	
Palo Alto	Stanford University	Urology	1/16/2003	-0-	-0-	
San Francisco	University of California, San Francisco	Radiation Services	2/4/2003	406,469	-0-	Yes
Richmond	Medical College of Virginia	Radiation Oncology	3/5/2003	-0-	-0-	
Omaha	Nebraska Health Systems	MRI Services	6/9/2003	-0-	-0-	Yes
Manhattan	New York University	Emergency Attending Physicians	6/17/2003	23,626	23,626	
Pittsburgh	University of Pittsburgh Physicians	Kidney Transplant Services	6/19/2003	343,396	343,396	
Madison	University of Wisconsin Hospital & Clinics	Organ Transplant Services	7/1/2003	2,445,156	654,385	Yes
Durham	Duke University Medical Center	Radiation Oncology	7/2/2003	394,187	-0-	
Salt Lake City	University of Utah	Radiation Oncology	7/21/2003	-0-	-0-	Yes
Durham	Private Diagnostic Clinic (Duke University)	Primary Care	7/22/2003	-0-	-0-	

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2003 (cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Omaha	University of Nebraska Medical Center	Nurse Practitioner & Pacer Technician Services	8/12/2003	\$82,988	-0-	
Pittsburgh	University of Pittsburgh Physicians	Cardiac Surgeon	8/14/2003	472,715	472,715	
Minneapolis	University of Minnesota Physicians	Urology Surgeon	8/19/2003	-0-	-0-	
Indianapolis	Indiana University	Urology Surgeon	8/20/2003	-0-	-0-	
Lexington	University Kentucky Medical Center	Emergency Cardio Thoracic Services	8/21/2003	-0-	-0-	Yes

FY 2004

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Miami	University of Miami	Anesthesiology	10/29/2003	709,555	N/A	
Salt Lake City	University of Utah Hospitals & Clinics	Heart Transplant & LVAD/RVAD Services	10/29/2003	649,200	-0-	Yes
Kansas City	University of Kansas Medical Center	Otolaryngology	11/7/2003	*	*	
Chicago	Northwestern Memorial Hospital	Liver Transplant Services	11/17/2003	-0-	-0-	Yes
New Jersey	University of Medicine & Dentistry of New Jersey	Radiology	11/24/2003	399,429	N/A	

* Recommended no award

N/A – Not awarded as of October 15, 2004

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2004 (Cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Palo Alto	Stanford University	Vascular Physician Services	11/24/2003	\$462,514	-0-	
Richmond	Medical College of Virginia Physicians	Radiation Oncology	12/9/2003	423,880	\$400,976	
Palo Alto	Stanford University	Cardiothoracic Physician Services	12/15/2003	403,087	17,205	
Indianapolis	Indiana University	Allergist	1/7/2004	14,620	N/A	
Durham	Duke University Health Systems	Anesthesiology	1/16/2004	1,074,040	N/A	
Pittsburgh	University of Pittsburgh Physicians	Critical Care Medicine Physician Services	2/4/2004	*	*	
Philadelphia	University of Pennsylvania Health Systems	Interim Cardiac Surgery	2/24/2004	*	*	Yes
Palo Alto	Stanford University	Anesthesiology	3/1/2004	341,115	341,115	
San Francisco	University of California, San Francisco	Anesthesiology	3/2/2004	66,765	N/A	
Minneapolis	University of Minnesota Physicians	Cardiac/Thoracic Surgical Services	3/9/2004	506,512	-0-	
Salt Lake City	University of Utah	Hematology/Oncology	3/25/2004	921,556	N/A	
Indianapolis	Indiana University	Vascular Tech	4/2/2004	261,926	N/A	

* Pricing analysis not completed because the solicitation and proposal required significant revisions to determine whether prices were fair and reasonable.
 N/A – Not awarded as of October 15, 2004

EVALUATION OF VHA SOLE-SOURCE CONTRACTS WITH MEDICAL SCHOOLS AND OTHER AFFILIATED INSTITUTIONS

Appendix A

FY 2004 (Cont.)

VAMC	Contractor	Services	Date Completed	BUOF	Sustained	Performed at Affiliate
Omaha	University Medical Associates of Nebraska	Anesthesiology	3/16/2004	\$564,134	\$327,101	
Indianapolis	Indiana University	Vascular Surgeon	4/2/2004	1,775,424	N/A	
Reno	University of Nevada, Reno	Medical Officer of the Day	6/17/2004	17,376	N/A	
New York City	New York University	Radiology	7/6/2004	*	*	Both
Pittsburgh	University of Pittsburgh Physicians	Anesthesiology	9/22/2004	162,651	N/A	
Miami	University of Miami	Ears, Nose, and Throat	9/28/2004	281,305	N/A	
Pittsburgh	University of Pittsburgh Physicians	Critical Care	9/28/2004	54,106	N/A	
Phoenix	Mayo Clinic	Ophthalmology	10/8/2004	2,323,375	N/A	

* Pricing analysis not completed because the solicitation and proposal required significant revisions to determine whether prices were fair and reasonable.
 N/A – Not awarded as of October 15, 2004

TOTALS FY 2000-2004	72 Pre-Awards			\$24,875,719	\$10,216,452	
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Canceled

VAMC	Contractor	Services		Status		Performed at Affiliate
Pittsburgh	University of Pittsburgh Physicians	Physical Therapy		Canceled		
Pittsburgh	University of Pittsburgh Physicians	Physical Therapy		Canceled		
Omaha, NE	University of Nebraska	Radiology Services		Canceled		
Indianapolis, IN	Indiana University	Radiology Services		Canceled		
Palo Alto, CA	Stanford University	Vascular Physician		Canceled		
Chicago, IL	Vanderbilt University	Liver Transplant Services		Canceled		Yes
Palo Alto, CA	Stanford University	Cardiothoracic Surgery		Canceled		
Iowa	University of Iowa	Radiology Services		Canceled		
Winston-Salem, NC	Wake Forest University	Off-site Colonoscopy Services		Canceled		Yes

Post-Award Reviews for Sole-Source Contracts with Affiliates

VAMC	Contractor	Services		Status		Performed at Affiliate
Kansas City	University of Kansas	ENT		Post-Award		
Omaha, NE	University of Nebraska/Creighton University	Psychiatry Services		Post-Award		
Salt Lake City	University of Utah	LVAD/RVAD Claim		Post-Award		Yes

Acting Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 4, 2005

From: Acting Under Secretary for Health (10/10B5)

Subject: **OIG Draft Report: Evaluation of VHA Sole-Source Contracts with Medical Schools And Other Affiliated Institutions**

To: Inspector General (50)

1. The referenced draft report has been carefully reviewed by VHA program officials. As part of our efforts to assure that each of your findings and recommendations was fully addressed, I requested that the already active Medical Services Procurement Work Group convene in VACO during the first week of November 2004 to design a framework for VHA's response. In addition to commenting on report recommendations, the work group also made revisions to the draft VA Directive, Health Care Resources Contracting – Buying, Title 38 U.S.C. 8153. Those draft comments and revisions formed the basis for several in-depth follow-up discussions with members of your staff to try to resolve key areas of potential disagreement. I am pleased to say that these collaborative efforts produced important points of clarification and compromise. As a result, we are now able to concur in all of your recommendations. One of the recommendations (Issue 3, No. 3, Conflict of Interest and Other Legal Issues), involving personal services contracts, will require legislative authority, which we will seek through the proper channels. Our plan of corrective action is attached.

2. VHA recognizes that flaws exist in contracting processes throughout the system and that effective accountability controls are lacking. As you are aware through active participation in our efforts, VHA officials have been grappling at the national level for several years with the myriad legal, administrative and ethical complexities that are involved in contracting for health care services with our affiliates. Based on extensive deliberations of the referenced work group, and following consensus by all levels of key Departmental officials, the referenced draft directive was finalized for publication and provided to your office for final concurrence. As already noted, revisions have been made to the directive that reflect your concerns, and finalization of the document is anticipated in the near future. We hope to use this national directive as the cornerstone in systematizing our sole source contracting policies throughout VHA.

3. While issuance of this comprehensive new directive to all field facilities is a fundamental first step, I recognize that VHA must also assure that the requirements set forth are universally implemented. As part of our preliminary oversight design, we are incorporating a series of planned checks and balances such as development and provision of various technical training programs, network director performance measures, review by the chief business officers, and contracting officer certifications to measure systematic compliance with the directive. At the Departmental level, more formal oversight will be provided by the Office of Regulation Policy and Management, which will be responsible for coordinating an overall plan for ongoing monitoring of compliance efforts. We will also continue to assess patterns and trends identified through your CAP reviews.

4. I thank you and your staff again for the collegial assistance that was provided in addressing identified concerns, and look forward to updating your office on the progress we hope to achieve through our planned corrective actions. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(original signed by:)

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

VHA Action Plan

Following are each of the specific recommendations made by the Office of Inspector General (OIG) in their draft report, Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, and the responses developed by the Medical Services Procurement Process Work Group during the week of November 1 – 5, 2004. In an effort to respond to these recommendations in a pro-active manner, the Work Group revised a draft VHA Directive, now entitled “VHA Health Care Resources Contracting – Buying, Title 38 USC 8153,” to reflect issues raised by OIG.

Issue 1 - General Contracting Issues

- 1. Require VA facilities to conduct and document adequate acquisition planning by:**
 - A. Assembling an acquisition team, which includes the contracting officer, as required by VAAR 873.105. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**
 - B. Justifying the need to contract for physicians and other health care providers as opposed to hiring them directly and, if contracting is required, justifying the need for a sole-source contract with the affiliate versus competitively contracting for these services. The justification should include comparison of compensation packages (salary and benefits) for providers doing the same level of work in the local area, not just the**

affiliate, and documentation of efforts to recruit. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.

C. Ensuring that there is adequate lead time for acquisition planning. We recommend 6-9 months for a new requirement and 3-6 months for a renewed requirement. (Concur – The policy will include a section specifically addressing processes to be followed in the event of an urgent need. The process to request Interim Contract Authority, as well as estimated timeframes to complete the entire contracting function will be included in the VHA Health Care Resources Contracting – Buying Directive.

D. Ensuring that the procuring facility has an alternate plan to obtain the necessary services in the event VA cannot negotiate fair and reasonable pricing, or terms and conditions with the affiliate. (Concur – Alternate plans will be established in the event a contract cannot be awarded. This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.

2. Develop a standard that defines the patient care workload expected from one FTE for a given specialty in terms that can be applied by the contracting community to determine the number of FTE required to provide a given amount of health care under the contract. (Concur - Staffing standards are in the process of being developed and implemented. Primary care standards have been developed. Specialty staffing standards are being developed. This recommendation is also being addressed in other OIG reports (Audit of Veterans Health Administration's Part-Time Physician Time and Attendance, Report No. 02-01339-85; Follow-Up Review of the VHA's Part-Time Physician Time

and Attendance, Report No. 03-02520-85; Evaluation of Nurse Staffing in VHA Facilities, Report No. 03-00079-183). As information becomes available to develop productivity and staffing guidelines, facilities will incorporate those in future contract requirements. In the interim, statements of work will attempt to be more definitive in identifying specific workload requirements.)

3. **Require competition for the procurement of health care services unless VA is a participant in an active residency training program in the specialty being procured. (Concur –This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**
4. **Ensure that legal and technical reviews are conducted before the solicitation is issued. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**
5. **Ensure that pre-award reviews by the OIG Contract Review and Evaluation Division are obtained for all proposals valued at \$500,000 or more, inclusive of option years, before contract award. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**
6. **Develop and implement policies that will ensure that contracting officers fully understand the services and responsibilities of the departments (e.g., radiology, anesthesiology, etc.) for which they are obtaining services. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**
7. **Ensure that contracting officers have independent authority for ensuring all contracts awarded to affiliates are in compliance with Federal and VA acquisition regulations, and are in the best interest of the Government. (Concur –This issue has**

already been addressed through VHA's CFO reorganization that now requires all contracting staff to report through a chain of command to the CLO, who, in turn, reports to the Deputy Network Director.)

8. **Develop and implement a national policy establishing requirements for recruiting by VA for VA positions to minimize the need to contract for health care services. (Concur – VA Directive and Handbook 5005 (Staffing) contains policy guidance for recruitment sources and strategies using flexibilities authorized on the type of advertising media used. A reference to the Directive and Handbook will be included in the proposed VHA Health Care Resources Contracting – Buying Directive. In addition, VHA is significantly involved at all levels in succession planning initiatives for mission-critical positions. (VA Handbook 5002 (Workforce and Succession Planning).**
9. **Restrict the electronic sharing of solicitations to “read only,” to ensure that terms, conditions, and other clauses cannot be amended by the entity submitting a proposal. (Concur –The requirement to use PDF documents will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.**

Issue 2: Contract Pricing

1. **Require that contracts for services to be provided at the VA medical facility be FTE based unless there is an approval from the VISN based on written justification that a procedure based contract is in the best interest of the Government. (Concur – We agree that FTE contracts are generally preferable. The Medical Center Director**

and Contracting Officer should decide the most appropriate basis for payment and what is in the best interest of the government. A per-procedure agreement can only be considered if the facility/network has a system in place for monitoring what procedures are being done, performance, and which physicians are performing the procedure. A billing process would also have to be established. This requirement will be included in the VHA Health Care Resources Contracting – Buying Directive.

2. Use Title 38 U.S.C. 7409 authority for sole-source contracts with the affiliate, and make the contracts cost-reimbursement, not firm-fixed price. (Concur with modification). Per discussion between General Counsel and OIG, the recommendation should be changed to read, “Consider the use of Title 38 U.S.C.7409 authority for sole source contracts with the affiliate and consider making the contracts cost-reimbursement, not firm-fixed price.” This language will be added to the proposed VHA Health Care Resources-Buying Directive.
3. Require all acquisition plans, when relevant, to document the justification for the number of FTE required under the contract. (Concur – This requirement will be addressed in the proposed VHA Health Care Resources – Buying Directive.
4. Require that the solicitation specify the percentage of time each FTE will spend in patient care and non-patient care activities, e.g., administrative duties, research, training, etc. (Concur – This requirement will be addressed in the proposed VHA Health Care Resources Contracting – Buying Directive.
5. Require that all FTE based proposals identify the key personnel who will provide the required services and the level of effort each physician is expected to provide. (Concur –This requirement

will be included in proposed VHA Health Care Resources Contracting – Buying Directive.

6. **Require terms and conditions in the contract that prohibit the affiliate from changing key personnel without VA approval and, when changes in key personnel are approved, that contract prices will be adjusted accordingly to reflect the salary and benefits of the personnel providing the services. (Concur – This requirement will be included in proposed VHA Health Care Resources Contracting – Buying Directive.**
7. **When multiple physicians are expected to provide services under the contract, compute annual, monthly, or hourly rates depending on the statement of work or other requirements in the solicitation, for each physician identified as key personnel. Require the affiliate and/or practice group to provide data showing the total number of hours each of the physicians is required, or expected, to work annually; and use this information to negotiate contract prices. (Concur – This requirement will be included in proposed VHA Health Care Resources Contracting – Buying Directive.**
8. **Establish a policy that delineates allowable overhead costs that is based on costs incurred by the affiliate that are allocable to the services being provided under the contract. (Concur – VA must consider what costs are legally allowable under FAR/VAAR, and will be stipulated in the proposed VHA Health Care Resources Contracting – Buying Directive.**
9. **Establish a policy specifying the expected on-call duty that VA physicians are expected to provide as part of their VA duties and responsibilities, and include the requirements in individual employment agreements. (Concur for full-time physicians. VHA policy already contains the requirement that all full-time physicians shall be continuously**

subject to call 24 hours per day, 7 days per week, unless officially excused by proper authority). For physicians who work both part time for VA and as VA contractors, we will include language that we encourage them to offer to provide on call coverage on a without compensation basis in the proposed VHA Health Care Resources Contracting-Buying Directive.

10. Establish a policy prohibiting the inclusion of additional costs for on-call duty unless it can be shown that the individual physicians receive supplementary compensation for on-call duty as part of their contractual agreements with the affiliate, and identify the circumstances, if any, in which it is appropriate for contract employees to have on-call responsibilities concurrently at VA, the affiliate, or other medical institution. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting - Buying Directive.
11. Establish a policy discouraging profit to the affiliate on sole-source contracts. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.
12. In those limited circumstances where a per-procedure based contract is deemed appropriate and necessary for services to be provided at VA, establish a policy requiring:
 - Medicare Part B rates will be the basis for pricing. () (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive. Related Medicare information can also be accessed on <http://klfmenu.med.va.gov/medicare/rvu.asp>.
 - The overhead (practice) component of Medicare Part B rates will be excluded from

the price paid. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.

- In those circumstances where some payment for overhead is appropriate, overhead will be included as a separate line item and pricing will be based on actual costs incurred. (Concur with separate line item for overhead, but pricing must be based on FAR 15.4 and FAR 31 requirements. This issue will be addressed in the proposed VHA Health Care Resources Contracting – Buying Directive.
- Contracts will be indefinite delivery, indefinite quantity (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.
- Payments will be based on the actual procedures performed, not estimated procedures. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.
- Contracts include provisions consistent with CMS regulations establishing the level of attending physician participation to be eligible for payment. (Concur – This requirement is already addressed in VHA Handbook 1400.1 Resident Supervision and will also be referenced in the proposed VHA Health Care Resources Contracting – Buying Directive.
- VA medical facilities to develop and maintain an information system that will provide accurate and complete information to evaluate the number and types of

procedures and examinations performed to ensure VA does not pay for services included in a global rate or performed by someone other than the contract provider. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.

- Solicitations delineate specific administrative responsibilities and that prices for duties will be negotiated as a separate line item. (Concur – This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.
- VA medical center to monitor performance and withhold payment if the administrative services are not provided. (Concur – When appropriate, VA will withhold payment in accordance with FAR. This direction will be included in proposed VHA Health Care Resources Contracting – Buying Directive.

13. Establish a policy for contracts for services to be provided at the affiliate that:

- Limits payments to Medicare Parts A and B rates, and adjust these rates to ensure VA is only paying for services provided at the affiliate. (Concur – Facilities will utilize Medicare rates as a basis in calculating rates but not as a payment limitation. Payments will be adjusted for services actually provided. This requirement will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.
- During contract negotiations VA will consider reimbursing pharmaceuticals in-kind, and pharmaceutical costs will be deducted from the Medicare Part A, or other negotiated rate unless an analysis of costs shows that it would be cost neutral or not

cost effective, or it would not be legally allowable. (Concur – This option will be included in the proposed VHA Health Care Resources Contracting – Buying Directive.

Issue 3: Conflict of Interest and Other Legal Issues

- 1. Provide mandatory training on conflict of interest laws and regulations and their applicability to all Title 38 employees who have a relationship with affiliates. (Concur – This issue has already been addressed via a July 15, 2004 memo to field facilities from the Deputy Under Secretary for Health for Operations and Management mandating this training.**
- 2. Develop and implement a policy that centralizes contracting activities with affiliates at the VISN level and prohibits local VA facilities from contracting with their affiliates. (Concur with Modification – The VHA CFO reorganization has centralized all contracts over \$25,000 at the Network level; however, facilities will continue to have authority to execute contracts under the \$25,000 threshold.)**
- 3. Work with OGC and, if necessary obtain an opinion from the Office of Legal Counsel at the Department of Justice, to determine whether the Secretary has authority under 38 U.S.C. 513 to enter into personal services contracts awarded to affiliates pursuant to the sole-source authority in 8153 and 7409. If 513 is not a viable option, we recommend that VA seek a legislative amendment to 38 USC 8153 and 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility. (Concur with Clarification– Per General Counsel, VA does not have authority to enter into personal services**

contracts. It will therefore be necessary to seek legislative authority through proper channels. VHA, in collaboration with the Department, will develop the request.

4. Take action to enforce the provisions of VHA Handbook 1660.3, requiring the Director of each medical center to ensure that each Chief of Staff and each physician supervisor or manager receive a copy of the handbook and acknowledge receipt by signing the acknowledgment form and have it placed in the individual's Official Personnel Folder. (Concur –This issue has also already been addressed in the referenced July 15, 2004 memo to the field from the DUSH for Operations and Management. The issue will also be referenced in the proposed VHA Health Care Resources Contracting – Buying Directive. In addition, the Buying Directive amends paragraph 4 of VHA Handbook 1660 3/1, by clarifying which VA employees must received the training and sign the Acknowledgement form.

OIG Contact and Staff Acknowledgments

OIG Contact	Maureen Regan (202) 565-8623
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Acknowledgments	John Ames
	Marci Anderson
	Michael Grivnovics
	Kristopher Teague

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