Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility personnel.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, members of Congress, or others.

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Executive Summary

Introduction

During the week of May 12-17, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Northern Arizona VA Health Care System (NAVAHCS). The purpose of the review was to evaluate selected healthcare system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to about 123 employees.

Results of Review

NAVAHCS patient care and QM activities reviewed were generally operating satisfactorily. NAVAHCS managers actively supported high-quality patient care and performance improvement. The QM program was comprehensive and provided appropriate oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, NAVAHCS managers needed to:

- Enhance contract administration by documenting the award process and monitoring contractor performance.
- Maintain accurate, complete, and current community-based outpatient clinic (CBOC) workload reporting data and reduce patient appointment waiting times.
- Reduce excess medical supply inventories and strengthen inventory controls.
- Strengthen QM activities by improving analyses and follow-up on identified issues and by enhancing physician participation in performance improvement activities.
- Improve clinical and administrative procedures for the Homemaker/Home Health Aide (H/HHA) Program.
- Implement pharmacy inventory requirements and ensure controlled substances inspections comply with Veterans Health Administration (VHA) policy.
- Correct physical security deficiencies in the pharmacy.
- Strengthen Government purchase card controls.
- Improve administrative controls in information technology (IT) security.

NAVAHCS Director Comments

The NAVAHCS Director agreed with the CAP review findings and suggestions and provided acceptable improvement plans. (See Appendix A, pages 15-26 for the full text of the Director's comments.) We consider all of the issues to be closed.

(*original signed by:*)

RICHARD J. GRIFFIN
Inspector General

Introduction

Northern Arizona VA Health Care System Profile

Organization. Based in Prescott, Arizona, the NAVAHCS provides a broad range of inpatient and outpatient healthcare services. Outpatient care is also provided at four CBOCs located in Kingman, Lake Havasu City (LHC), Bellemont, and Cottonwood, Arizona. The NAVAHCS is part of Veterans Integrated Service Network (VISN) 18 and serves a veteran population of about 19,000 in a primary service area that includes 5 counties in Arizona.

Programs. The NAVAHCS provides medical, ambulatory surgical, mental health, geriatrics, and advanced rehabilitation services. The NAVAHCS has 25 hospital beds, 85 nursing home beds in the Extended Care and Rehabilitative Center, and 120 beds in the Domiciliary, and operates an outpatient substance abuse treatment program and a vocational rehabilitation job-training program. The NAVAHCS also supports operations for the Prescott National Cemetery.

Affiliations. The NAVAHCS is affiliated with the Arizona College of Osteopathic Medicine to provide 30-day clerkships for medical students. The NAVAHCS is also affiliated with several universities to provide clinical training opportunities for nursing and allied healthcare students.

Resources. In Fiscal Year (FY) 2000, NAVAHCS medical care expenditures totaled $46.2 million. The FY 2001 medical care expenditures were $53.2 million, 15 percent more than FY 2000. FY 2001 staffing was 588 full-time equivalent employees (FTEE), including 20 physician and 175 nursing FTEE.

Workload. In FY 2001, the NAVAHCS treated 16,148 unique patients, a 23-percent increase from FY 2000. The inpatient care workload totaled 2,259 discharges, and the average daily census, including nursing home and domiciliary patients, was 199. The outpatient workload was 129,462 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality Veterans Affairs (VA) health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Agent cashier operations	Government Purchase Card Program
Part-time physician time and attendance	Information technology security
Service contracts	Acute medical units
Community-based outpatient clinics	Behavioral health care
Medical supply inventory management	Drug company representative contacts
Quality management	Means test certifications
Homemaker/Home Health Aide Program	Physical inventory of equipment
Controlled substances accountability	Primary care clinics
Pharmacy security	Rehabilitation and extended care

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to all clinical employees, 70 of whom responded. We also interviewed 30 patients during the review. The surveys indicated high levels of patient and employee satisfaction and did not disclose any significant issues. We provided the full survey results to NAVAHCS managers.

During the review, we also presented five fraud and integrity awareness briefings for NAVAHCS employees. About 123 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered NAVAHCS operations for FY 2001, and FY 2002, through April 2002, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make suggestions for improvement. Suggestions pertain to issues that are not significant enough to warrant OIG recommendations and follow-up but are submitted for the Director's consideration.

Results of Review

Organizational Strengths

NAVAHCS managers had created an environment that supported high-quality patient care and performance improvement. The patient care administration, QM, financial, and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

Community Collaboration in the Root-Cause Analysis Process has Improved Outcomes and Community Relations. All VHA facilities are expected to conduct root-cause analyses (RCA) on incidents that have, or potentially have, serious affects on patient care. NAVAHCS senior managers fully embraced the RCA methodology and invited community agencies to participate on RCA teams when situations were appropriate. Community participation included individuals from local ambulance companies, a regional medical center, a county detention center, and a county court. Each RCA generated appropriate corrective actions that resulted in process and system improvements for all agencies involved.

An Integrated Database Provides a Reliable System for Efficiently Accessing Data. NAVAHCS managers developed an integrated database to meet performance management and decision-making information needs. The system aggregates data and information from internal and external sources, including the hospital computer system, the Veterans Support Service Center, and the Allocation Resource Center. It contains links to other password-protected databases that allow managers to assess labor productivity and monitor service budgets at the unit and job levels. It allows immediate access to medical, performance, and financial information for decision-making and quality improvement purposes.

Controls for Agent Cashier Operations Were Effective. The NAVAHCS had implemented effective controls to protect agent cashier funds from fraud, waste, and abuse. The physical security of the agent cashier's space and equipment afforded adequate protection and security for agent cashier activities. Safe combinations, and duplicate keys to the agent cashier offices and cash boxes were under the proper custody of the Director. Employees who had no agent cashier responsibilities conducted unannounced audits on a random basis and in a timely manner. The agent cashier turnover rate was properly monitored, and the advance was appropriately adjusted to satisfy the facility's needs.

Part-Time Physician Time and Attendance Procedures Were Effective. NAVAHCS managers had established effective procedures and controls to ensure that part-time physicians' time and attendance records accurately reflected the numbers of hours physicians were on duty. Timekeepers verified physicians were present during their scheduled tours of duty and completed timecards based on their personal knowledge of the actual hours worked by physicians. Timekeepers had received the initial VA timekeeping policies and practices training, as well as annual refresher training. Managers conducted desk audits of timekeeper practices semiannually and implemented follow-up actions to address the desk audit results.

Opportunities for Improvement

Service Contracts – Noncompetitive Contract Pricing Documentation and Contract Monitoring Should Be Improved

Conditions Needing Improvement. NAVAHCS managers needed to improve contract award, negotiation, and administration procedures. Unless an acquisition is exempt from cost or pricing data requirements, the files of contracts awarded on a noncompetitive basis should contain the cost or pricing data obtained, the analyses of such data, and price negotiation memorandums (PNM) or statements of price reasonableness that thoroughly document the negotiation process. Also, contracting officers, contracting officer's technical representatives (COTR), and Fee Services Section personnel should closely monitor and review administrative, financial, and technical activities for compliance with contract terms. To determine the effectiveness of contract negotiations, award procedures, and contract administration, we reviewed 10 service contracts with an estimated value of about $1.4 million. The 10 service contracts included 8 commercial item contracts, 1 blanket purchase agreement, and 1 sharing agreement. We identified two weaknesses in contracting procedures that needed to be addressed.

Contract Award and Negotiation Procedures Needed to be Improved. We found three contracts did not contain PNMs or statements of price reasonableness documenting how prices on the noncompetitive contracts were established and substantiating that prices obtained were fair and reasonable. For example, a contract for radiology procedures with a sole-source contractor was entirely based on a submitted price list and the contractor's assertion that Medicare regulations required the contractor to offer the same prices to federal agencies. Although the contractor offered a 20-percent discount, we found that Medicare rates were substantially less than the rates submitted by the contractor. In some cases, the contractor's rates were three times the Medicare rates. More importantly, there were no cost or price analyses conducted and no PNMs or statements indicating that the prices established were fair and reasonable. Another contract had no price list for the contracted medical procedures. Therefore, there was no evidence substantiating that fair and reasonable prices were obtained, and the person certifying the invoices for payment had no basis for verifying that the contractor had properly billed NAVAHCS. NAVAHCS managers agreed further cost or price analyses were needed and that PNMs or statements of price reasonableness should be prepared to ensure fair and reasonable contract prices are obtained and supported. In addition, we identified a contracting officer who had not received any training on the required contracting procedures. NAVAHCS managers assured us they would provide training to the contracting employees on contract award, negotiation, and administration procedures. The contracting activity at the CBOCs was also affected by similar contracting deficiencies discussed on page 5.

Contract Activities Needed to be Monitored. The monitoring of daily contractor activities needed to be improved. Our review disclosed three contracts in which the employees certifying the invoices for payment had not reviewed the contractors' billed charges for compliance with the contract terms. Invoices should be carefully screened for contractor compliance with the terms of the contract to prevent the use of scarce resources for unnecessary payments. For example, our review of invoices submitted by a contractor disclosed an instance in which the

contractor submitted a separate invoice for services that were covered under a fixed monthly contract rate. The contractor submitted another invoice for the fixed monthly contract rate for these same services. NAVAHCS employees paid the contractor the Medicare rate of $90 for the separately billed services and also the fixed monthly rate for that month even though NAVAHCS should have only paid the invoice for the fixed monthly rate.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) noncompetitive contract prices are supported with cost or pricing data and analyses of such data are conducted; (b) PNMs or statements of price reasonableness are prepared and maintained in the contract files; (c) all contracting employees receive training addressing the contract award, negotiation, and administration requirements; and (d) contracting officers, COTRs, and Fee Services Section personnel certifying invoices for payment closely monitor contracting activities for compliance with contract terms. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Community-Based Outpatient Clinics – Contracting Practices, Workload Data, and Waiting Times Needed To Be Improved

Conditions Needing Improvement. NAVAHCS managers needed to improve contracting practices used to obtain CBOC clinical services and validate workload data. CBOC patient waiting times also needed to be reduced. We identified five weaknesses in CBOC contracting practices and workload reporting that needed to be addressed.

Documentation Supporting Price Reasonableness Needed Improvement. Our review disclosed three of seven CBOC service contracts, valued at about $21,000, did not document the method used to determine that contract prices were fair and reasonable. The seven contracts were valued at about $175,000. The three contracts contained price lists for the services to be provided by the contractors, but there was no evidence that cost or price analyses of such data were conducted. Although VHA prescribes the Medicare rates as the benchmark for VA procedure-based contracts, we also found the accepted prices for some contracts were much higher than Medicare rates. For example, we found one contract for laboratory tests and radiology readings included prices for services that were as much as 300 percent higher than the Medicare rates.

Payments to Vendors Should be Based on Contract Prices. We found that two contractors performed and billed for several services that were outside the scopes of their laboratory testing and radiology reading contracts. NAVAHCS employees paid the invoices for these services even though they were outside the scopes of the contracts. If contracting or fee-services personnel had compared services shown on invoices with contract terms, they would have identified these discrepancies.

Workload Data Needed to be Verified For Accuracy. Our review disclosed that VHA's patient encounter data maintained by the Austin Automation Center (AAC) did not match the patient encounter data maintained by the NAVAHCS. For example, the AAC's National Primary Care Management Module (PCMM) data showed that a provider at the LHC CBOC and another provider at the Kingman CBOC had a total of 291 patient encounters in April 2002. However,

NAVAHCS PCMM data for the same period showed that these 2 providers had 2,737 patient encounters. CBOC personnel attributed differences to difficulties in transmitting NAVAHCS' data to VHA's National PCMM database at the AAC. CBOC personnel further explained that the data problems have been historically traced to erroneous loading of PCMM computer patches at the NAVAHCS. It is important that patient encounter data transmitted to the AAC be accurate. Accordingly, unique patient encounter data should be validated to ensure the VHA's national database is accurate.

Waiting Times Needed to be Reduced. VA's FY 2001 Annual Performance Report made it a priority goal for VHA to provide access to primary and specialty care appointments within 30 days. Patients interviewed during our visit to the LHC CBOC claimed they were not receiving initial appointments at LHC for 10 to 12 months. LHC CBOC employees agreed that patients had to wait extended periods to get appointments. As of April 2002, the NAVAHCS' workload data showed that the average waiting time at LHC was about 7 months for initial appointments. Managers needed to address waiting times to ensure that VA goals are met.

Patient Enrollment Data Needed to be Updated. The Primary Care staff are required to update the PCMM database for patients who have not been seen in 2 years or do not have future appointments. We found that prior to May 13, 2002, NAVAHCS employees had not periodically updated the PCMM database to ensure the accuracy of the patient enrollment data at the CBOCs. However, management informed us that effective May 13, the PCMM database would be updated monthly. This is supported by the May 13, 2002, updating of the PCMM database in which 122 inactive patients were removed from the NAVAHCS' 4 CBOCs.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) the required data are obtained and analyzed to establish fair and reasonable CBOC service contract prices; (b) contracting officers, COTRs, and Fee Services Section personnel certifying invoices for payment closely monitor contracting activities for compliance with contract terms; (c) encounter, appointment scheduling, and patient enrollment data are periodically checked for accuracy and completeness and maintained on a current basis; and (d) waiting times are reduced for initial appointments. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Medical Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Conditions Needing Improvement. NAVAHCS managers needed to improve medical supply inventory management. In October 2000, the VHA established a 30-day goal for medical supply inventories to lower holding costs, reduce stock depletions by automating the replenishment process, and eliminate outdated items. VHA further required that facilities use the automated Generic Inventory Package (GIP) to manage and monitor inventories. Facilities should also complete periodic, physical inspections to ensure the accuracy of inventories. To evaluate the effectiveness of inventory management, we compared the GIP inventory levels with the average use of each item during the 12-month period that ended March 2002. We also reviewed a total

of 20 inventory line items in the NAVAHCS' Materiel Management Office (MMO) and Supply Processing and Distribution (SPD).

Medical Supply Inventories Needed to be Reduced. NAVAHCS managers needed to improve medical supply inventories monitoring to achieve the 30-day medical supply goal. Based on GIP records, we found the inventory levels for 736 (84%) of 875 line items in MMO and SPD exceeded the 30-day supply goal. The total value of the inventory was $115,266, and the value that exceeded the 30-day goal was $68,748. A further breakdown of the excess medical supply inventory indicated $17,046 was located in MMO and $51,702 was located in SPD. Many of these items had no demand for extended periods. For example, 422 line items valued at $45,731 had no demand during the previous 12 months.

SPD Needed to Conduct Periodic Physical Inventories. Our review to determine the accuracy of GIP data for 20 line items (10 line items in MMO and 10 line items in SPD) found that the MMO data was 100 percent accurate, but the SPD records were inaccurate for 8 of 10 line items. Of the 8 inaccurate line items, 3 line items had a recorded GIP value of $3,049, but our review disclosed this amount was understated by $7,586. The remaining 5 line items had a recorded GIP value of $1,963, but our review disclosed this amount was overstated by $1,109. While MMO employees performed periodic, physical inventories to verify GIP accuracy, SPD employees indicated they did not implement this practice due to a lack of personnel. SPD personnel agreed that reported quantities were inaccurate, and a physical inventory of all items was needed to update the GIP records.

MMO and SPD employees indicated they had begun working on reducing inventories by developing an inventory management plan that will address these deficiencies. For example, SPD was organized under the Clinical Care Support Line but was going to be placed under Facilities Management, which already oversees MMO. This organizational change was expected to provide increased oversight of the medical supply inventory maintained in SPD. Also, MMO and SPD managers planned to implement the use of bar coding and scanning equipment to accelerate inventory monitoring.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) excess inventories are reduced to 30-day supply levels, (b) a physical inventory of SPD is completed, and (c) bar coding and scanning equipment are used to verify inventories. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Quality Management – Facility Managers Needed to Improve Documentation, Follow-up, and Physician Participation

Conditions Needing Improvement. The QM program was comprehensive and provided appropriate oversight of patient care delivered at the NAVAHCS. However, managers did not consistently present data, state specific actions, or follow through on identified action items. In addition, managers did not ensure that physicians consistently attended Performance Improvement Council (PIC) meetings or participated in related activities.

To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files.

Improvement Opportunities Were Not Consistently Documented and Tracked Until Resolved. To facilitate results that improve quality, safety, and cost effectiveness, managers must properly coordinate and clearly document the QM process. We concluded that NAVAHCS managers did not consistently identify appropriate interventions or follow up on action items that were identified in the various quality review processes. For example, PIC meeting minutes reflected an ongoing problem with clinicians failing to educate patients prior to specific gastrointestinal procedures. However, there were no action items, assigned responsibilities, or target dates to demonstrate that corrective actions were implemented. Interventions frequently cited in various committee meeting minutes included 'continue to monitor' and 'information only.' Patient complaint data were collected and analyzed over time; however, reports lacked conclusions, follow-up, and trending by area or provider. In addition, medication usage analyses were delayed when monthly meetings were cancelled for 4 consecutive months. The Quality Programs Manager (QPM) agreed that the results of quality monitors needed to be better analyzed, addressed with appropriate action items assigned to specific managers, and tracked until resolution is achieved.

Physician Participation in QM Activities Was Not Adequate. Each medical facility is expected to have medical staff involvement in quality management activities. During a 6-month period, only one PIC meeting had physician representation. In addition, granting clinical privileges to independent practitioners did not include documented consideration of quality improvement activities. The QPM agreed that more physician participation was needed in the QM process and that specific activities should be reviewed and considered at the time each provider is re-privileged.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) QM activities are more consistently analyzed and tracked until resolved, and (b) physicians are more involved in QM activities and that their participation and contributions are reflected at re-privileging. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Homemaker/Home Health Aide Program – Clinical and Administrative Procedures Should Be Improved

Conditions Needing Improvement. The H/HHA Program's patient assessment procedures and oversight practices should be improved.

VHA Directives prescribe implementation of several non-institutional programs to accomplish VA's long-term care goals, such as the H/HHA Program. The H/HHA Program provides homemaker or home health aide visits to eligible beneficiaries. VHA facilities are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs.

The NAVAHCS implemented the H/HHA program in September 2001, and authorized H/HHA services for 22 patients during FY 2002. At the time of our visit, the facility had contracted with 16 Community Health Agencies (CHAs) and was providing services to 9 patients. All CHAs were state licensed.

To determine the effectiveness of H/HHA processes and controls, we evaluated the medical documentation of all nine patients enrolled in the H/HHA program, and we interviewed the H/HHA Coordinator and several patients. The patients told us that they were satisfied with the services and that having a homemaker or a home health aide had helped them maintain their independence and remain in their own homes. We identified the following conditions that needed to be corrected:

Patient Assessments Were Not Properly Documented. Only one of the nine medical records contained evidence of an interdisciplinary team assessment by a physician, a nurse, and other pertinent allied health professionals. The team must provide the CHA with a complete referral package that includes clinical need and administrative eligibility. The only documentation we found was the coordinator's notes and consultation forms that contained minimal patient information.

Evaluation of H/HHA Services Was Not Properly Documented. We did not find any evidence that CHA performance improvement (PI) data and quarterly patient assessments were used to evaluate the quality of H/HHA services and the need for continued care. The H/HHA Coordinator told us that she routinely talked with employees at the CHAs about PI activities and patient care issues before continuing services. However, we found no documentation in the patients' medical records to support this assertion.

Existing Contracts Needed to be Utilized. The Program Coordinator needed to use existing contracts when H/HHA services were needed. The Program Coordinator made separate arrangements with vendors on a case-by-case basis for H/HHA services. However, the NAVAHCS contracting department had existing contracts, with established contract terms, with various H/HHA vendors. By using these established contracts, NAVAHCS may be able to better utilize its scarce resources and avoid possibly higher rates for H/HHA services made outside the scope of the existing contracts.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) complete interdisciplinary assessments are documented on all patients referred to the H/HHA Program; (b) H/HHA Program managers review quarterly CHA performance improvement data and patient assessment reports to monitor quality of care and need for continued services; and (c) H/HHA services are obtained using existing contracts. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Controlled Substances Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. NAVAHCS managers needed to address weaknesses in the pharmacy controlled substances inventory verification process and the unannounced controlled substances inspection program. All controlled substances, including excess, outdated, and unusable items, located in the pharmacy should be verified every 72 hours by pharmacy personnel. VHA established a 10-day supply goal for controlled substances inventories to lower holding costs and reduce outdated items. Inspectors are required to conduct monthly, unannounced inspections to ensure they are able to account for all controlled substances.

To assess controlled substances accountability, we interviewed pharmacy employees, compared the inventory levels for a sample of 10 controlled substances in the pharmacy to purchases for the 12-month period that ended May 16, 2002, and toured and physically inspected drug storage areas. We also interviewed controlled substances inspectors, observed inspections in the pharmacy, urgent care, and one ward, and reviewed inspection reports for the 12-month period that ended March 2002. We identified three weaknesses in inventory and inspection procedures.

Inventory Verification Requirements Needed to be Met. Pharmacy employees did not verify all controlled substances inventories, including excess, outdated, and unusable controlled substances, every 72 hours as required. Employees did not inventory the excess, outdated, and unusable controlled substances held for destruction in the pharmacy until they were about to be shipped to a licensed contractor for destruction. Pharmacy managers stated that they did not have enough employees to perform this procedure three times a week. Instead, pharmacy employees implemented a practice in March 2002, of verifying controlled substances inventories once a week. During our observation of a controlled substances inspection in the pharmacy, inspectors identified 4 of 142 controlled substances that had discrepancies that could not be resolved. While the discrepancies were small, a 72-hour verification of the inventory might have identified these discrepancies earlier.

Inventories Needed to be Reduced. A review of 10 line items of controlled substances in pharmacy stock found that 9 line items exceeded VHA's 10-day supply goal. The total value of those line items exceeding the 10-day supply goal was approximately $2,200.

Dose Verifications Should be Completed. Controlled substances inspectors did not compare samples of controlled substances from ward dispensing entries with patients' records to determine if the doses were documented and supported by physicians' orders as required. This had not been done since 1998, because the former Chief Nurse objected that this requirement was too burdensome on nursing personnel. The controlled substances inspection coordinator agreed the dose verifications were important and began developing a training program for controlled substances inspectors during our review.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) all controlled substances in the pharmacy are verified every 72 hours, including excess, outdated, and unusable controlled substances, and that all inventory verification policies and procedures are followed; (b) excess pharmacy stock levels are reduced to 10-day supplies; and (c) the

controlled substances inspection program comply with VHA policy. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Pharmacy Security – Physical Security Should Be Improved

Conditions Needing Improvement. NAVAHCS managers needed to improve physical security in the pharmacy. VHA directives require facilities to maintain effective security controls to prevent unauthorized access to controlled substances storage areas and ensure all controlled substances are physically secure. To evaluate pharmacy security controls we visited and inspected pharmacy dispensing and storage areas, reviewed security policies and procedures, and interviewed pharmacy and security personnel. We identified two security weaknesses that needed to be addressed.

The Controlled Substances Vault Should be Strengthened. The controlled substances vault should be improved to comply with VA policy. This was discussed in detail with NAVAHCS management and is not being further detailed here.

Keypads Needed to be Better Protected. The three doors to the pharmacy and the controlled substances vault door were protected with keypad electronic locks. However, these keypads were not covered with hoods or any other means to prevent others from observing access codes being entered by authorized persons entering these areas. VHA directives require that electronic access safeguards prevent anyone from learning codes through keypad observations. All pharmacy employees had access to the pharmacy, but only seven pharmacists had access to the vault. The Police and Security Service identified this deficiency in a security survey of the pharmacy on November 30, 2001.

The Facilities Manager agreed that the construction of the controlled substances vault did not comply with VA policy, and the keypads needed to be improved. NAVAHCS managers planned to address these deficiencies in an upcoming pharmacy-remodeling project.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) construction materials in the pharmacy comply with VA policy; and (b) the electronic keypads are protected to prevent unauthorized observation of access codes entered by authorized pharmacy personnel. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Government Purchase Card Program – Controls Needed To Be Improved

Conditions Needing Improvement. NAVAHCS managers needed to improve the controls over the Government Purchase Card Program. VHA facilities are required to use Government purchase cards for small purchases of goods and services. A small purchase is defined as a single purchase that is usually for $2,500 or less. VHA requires 95 percent of Government purchase card reconciliations to be completed within 17 days and that all purchase card charges

are reconciled or disputed before they are 30 days old. VHA further requires an approving official to certify, within 14 days of receipt of a cardholder's reconciliation, that procurements are legal and proper and that items have been received. Approving officials are responsible for ensuring that purchases are not split and are within authorized cardholder spending limits.

To evaluate Government Purchase Card Program controls, we interviewed the Program Coordinator and reviewed purchase card transactions and records. We identified two weaknesses in Government Purchase Card Program controls that needed to be addressed.

Government Purchase Card Reconciliations Were Not Timely. The Government Purchase Card Program at NAVAHCS processed 9,867 transactions totaling $2,939,724 for the 18-month period that ended March 2002. The purchase card reconciliations reviewed for the period were not always completed within prescribed timeframes. NAVAHCS employees reconciled 90 percent of the purchase card transactions within 17 days and 93 percent of the purchase card transactions within 30 days. The number of transactions not reconciled within 30 days amounted to 647 transactions valued at $190,698. According to the Program Coordinator, the overdue reconciliations resulted from cardholders ignoring policy and instructions. The overdue reconciliations prevented the approving officials from certifying purchase card transactions for payment because the approving officials needed the documentation that is generated from the reconciliation process to support these transactions.

Split Purchases Should be Eliminated. Our review disclosed that the splitting of purchases to circumvent cardholders' spending limits was a common practice at the NAVAHCS. We reviewed a sample of 23 purchase card transactions valued at $41,311 to determine if cardholders had split purchases to circumvent their assigned spending limits for single purchases. Of the 23 purchase card transactions, we identified 16 purchase card transactions valued at $27,500 wherein purchases were split to circumvent the cardholders' spending limits. This occurred because approving officials were not monitoring purchase card transactions to prevent the practice of splitting purchases. The process of approving officials certifying purchase card transactions is an important monitoring tool since this ensures that purchases are within the cardholders' authorized purchase limits, purchases have applicable supporting documentation, and purchases over $2,500 are not split to circumvent spending limits.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) cardholders comply with Government Purchase Card Program policies for completing reconciliations, and (b) cardholders are instructed to comply with VHA policy limiting single purchases to $2,500 and approving officials monitor purchasing activity to ensure cardholders comply with their authorized spending limits. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

comply with their authorized spending limits. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Information Technology Security – Policies and Procedures Needed To Be Improved

Conditions Needing Improvement. NAVAHCS managers needed to improve controls over the Information Security Officer (ISO) function and the Contingency Disaster Plan. Automated information systems security policy and guidelines recommend separation of the ISO function from the Information Systems Service Line (ISSL). VHA directives require the facility Contingency Disaster Plan to be documented and continually updated since the personnel responsible for the implementation of the plan and other factors may change. The Contingency Disaster Plan needs to be periodically tested to identify and correct any problems resulting from the execution of the plan and should include an alternative processing site for emergent situations. VHA further requires that systems backup data be tested on a regular basis to ensure that data can be restored when needed and that such data must be stored in a secure off-site location. We identified three weaknesses in IT security that needed to be addressed.

ISO Duties Needed to be Segregated. The ISO reported to the NAVAHCS Director but also performed day-to-day duties in the ISSL and was supervised by the ISSL Manager. The ISSL Manager had not identified duties in ISSL that could be incompatible with the ISO's duties and responsibilities. Key positions, including ISO, must be properly segregated to prevent a single person from having too much control and the ability to initiate, develop, implement, and approve changes to a system or process. If the proper checks and balances are not in place, the risk of being exposed to problems will remain high. Management controls should be enhanced by ensuring the IT functions performed by the ISO will in no way be associated with his responsibilities to develop, implement, and monitor information security policy and procedures.

The Contingency Disaster Plan Needed to be Improved and Tested. The key personnel directory included in the Contingency Disaster Plan was outdated. In the event of an emergency, personnel would not be able to contact the responsible officials since the names and telephone numbers contained in the key personnel directory were those of former employees. The Contingency Disaster Plan also was not tested according to the plan's instructions. The plan established different levels of testing, but the ISO had no documentation showing any testing occurred for different levels of the plan. Additionally, the Contingency Disaster Plan did not include an alternative processing site in the event that a disaster destroyed the facility. The ISO was not aware that the term "alternate processing site" meant that the location had to be away from the facility and that the location had to be included in the plan. In the event of a disaster at the facility, the lack of an off-site location poses a significant risk to the continuing business and medical functions of the facility.

Backup Data Should be Regularly Tested. Systems backup data was not tested on a regular basis to ensure that data could be read from electronic media, and the data was not securely stored at an off-site location. If systems backup data is not tested on a regular basis and stored in a secure

off-site location, the facility cannot ensure that critical information can be properly restored in order to continue business and medical functions during times of disruptions.

Suggested Improvement Actions. We suggested that the NAVAHCS Director ensure that: (a) ISSL managers establish a policy that identifies incompatible IT duties; (b) the key personnel directory of the Contingency Disaster Plan is updated when staffing changes occur; (c) the Contingency Disaster Plan is periodically tested for effectiveness according to the plan's instructions; (d) an alternative processing site is established; and (e) systems backup data is regularly tested and stored at an off-site location. The Director agreed and submitted plans for improvement. The improvement actions and planned actions are acceptable.

Northern Arizona VA Health Care System Director Comments

Department of Veterans Affairs **MEMORANDUM**

Northern Arizona VA Health Care System

Date: August 27, 2002

From: Health Care System Director, Northern Arizona VA Health Care System (649/00)

Subject: **Revised Draft Report** – Combined Assessment Program Review of the Northern Arizona VA Health Care System – Project Number: 2001-02641-HI-0479

To: Office of Inspector General
Thru: Director, Southwest Health Care Network (10N18)

1. Thank you for the opportunity to respond to your Combined Assessment Program Review draft report for the Northern Arizona VA Health Care System. While no formal recommendations were made, my comments pertaining to the suggestions made by the team are enclosed.

2. If you have further questions regarding the comments, do not hesitate to contact me.

(Original signed by:)
Patricia A. McKlem

Suggested Improvement Actions

Service Contracts
Ensure that: (a) noncompetitive contract prices are supported with cost or pricing data and analyses of such data are conducted; (b) PNMs and statements of price reasonableness are prepared and maintained in the contract files; (c) all contracting employees receive training addressing the contract award, negotiation, and administration requirements; and (d) contracting officers, COTRs, and fee service section personnel certifying invoices for payment closely monitor contracting activities for compliance with contract terms.

Comments:
Concur with findings and suggestions
An audit of all current 2237s and contracts is being completed to identify deficiencies. For those not supported with cost or pricing data and/or without a price negotiation memorandum or statement of price reasonableness, documentation will be completed and contracts will be re-negotiated where needed.

NAVAHCS contracts with Southern Arizona VA Health Care System (SAVAHCS) to function as Head Contracting Authority and for the provision of contracts greater than $25,000. The Contract Specialist from SAVAHCS spent one week on site with NAVAHCS staff. He worked with a Purchasing Agent, assessing her knowledge, skills, and ability for the purpose of developing a training plan. He provided assistance in proper contracting procedures and conducted training for COTRs. COTRs are responsible for correct certification of invoices. New COTR and yearly refresher training is being developed.

An audit of all payments made this fiscal year is being completed to verify certification of invoices. Bills of Collection will be issued to vendors for overpayments made as a result of incorrect certifications.

Review/audit procedures are being established and/or expanded to ensure on-going compliance with contracting procedures.

Planned actions will be completed in phases with a completion target date of 10-1-02.

Community Based Outpatient Clinics
Ensure that: (a) the required data are obtained and analyzed to establish the fair and reasonable CBOC service contract prices; (b) contracting officers, COTRs, and fee service section personnel certifying invoices for payment closely monitor contracting activities for compliance with contract terms; (c) encounter, appointment scheduling, and enrollment veteran patient data are periodically checked for accuracy and completeness and maintained on a current basis; and (d) waiting times are reduced for initial appointments.

Comments:
Concur with findings and suggestions
In the CBOC contracts referenced, contracts for emergency services are solicited in the communities where CBOCs are located. The CBOCs established by NAVAHCS are all located in small rural communities with limited health care support structure. In these types of communities, there are a very limited number of providers such as radiology services, laboratory services, and radiology reading services. In these communities, the capacity available for additional customers is extremely limited leaving vendors complete latitude to accept or not accept new customers. The quantity of services procured, which normally allows a vendor to lower pricing based on anticipated volume is very low since the contracts are for emergency requirements only. Routine or non-emergent support services are referred to and performed at the parent facility in Prescott.

In initiating contracts for CBOC support services, the prices proposed by vendors were reviewed and compared to prices that the vendor charged other entities in the community requiring similar volumes and services. Prices were also considered against the cost of providing services through alternative methods. Two alternatives were considered: (1) that the patient with an emergency need would have to be sent to the local community medical center or (2) the patient would be transported to the parent facility in Prescott. Both alternatives were determined to be unacceptable for various reasons, the most prominent being the extremely higher cost. As an example, a patient sent to the local medical center for an x-ray would be required to enter through the emergency department thereby incurring a cost of $800 for an emergency room visit and an additional cost for the x-ray and reading. The second option, that of referring to the parent facility in Prescott would require the facility to arrange and pay for transport of the patient to Prescott. As an emergency transport,

the lowest level of transport acceptable would be stretcher van, which would result in a one-way cost in excess of $500. It was further determined that the required type of support transport service was not available in three of the four communities wherein CBOCs are located.

Although this fair and reasonable price determination was conducted when the contracts were established, documentation of this analysis was not in the contract file. Monitors are being initiated to assure compliance with appropriate contract documentation.

Contracting for services within VHA is performed through the methods of competition (where available) or negotiation (where appropriate). Utilization of the contract method of acquiring services allows the Health Care System to be able to specify the quantity, quality, and scheduling timeframes necessary to meet the medical needs of providers and patients. Vendors in medically under-served areas such as the small communities wherein the CBOCs are located generally have full or nearly full practices. In most of these communities, local/regional medical centers and a very limited number of private service providers represent the total available competition. (See Attachment 1.) The availability of competition and a market that has an excess medical capacity, such as in a metropolitan area like Phoenix or Tucson allows vendors to reduce rates to the Medicare level. In the smaller rural community, vendors are reluctant to reduce their rates to Medicare rates. Title 38, Code of Federal Regulations (CFR), Part 17 will be used as reference when negotiating these medical service contracts with non-VA facilities.

The services performed and paid for outside of the contract scope were services ordered and received by NAVAHCS. These services were determined medically necessary by CBOC providers and scheduled locally when they could have been referred to the parent facility. Inclusion of all possible vendor services in every contract is not appropriate. In any remote medical operation, there will be instances wherein the medical provider's determination of urgent need will supercede a contractual document. In those rare instances, education after the fact to process through Fee Basis or refer to the Prescott facility will generally result in prevention of future occurrences. When noted in the future, the person(s) authorizing payment will make appropriate notations on the invoice and document the training/retraining of the appropriate provider(s).

The OIG CAP Review disclosed that Primary Care Management Module (PCMM) data specific for NAVAHCS at the Austin Automation Center (AAC) did not match data maintained by NAVAHCS. Normally, data from the NAVAHCS PCMM is automatically transmitted to the AAC twice daily so that the two databases have accurate, updated, matching information. Over a year ago, our system stopped transmitting this twice-daily updated information automatically and, we were unaware until recently. This is being corrected, and a process is being developed so that NAVAHCS and AAC PCMM databases are compared twice monthly following the updated schedule that the AAC publishes on their web page.

Although waiting time averages for all NAVAHCS' Primary Care Clinics is under 30 days, there is a significant waiting time for new applicants to the Lake Havasu City (LHC) CBOC. There are two full time Primary Care Providers (PCP) at that CBOC. The number of new applicants for care has exceeded our PCP capacity since January of 2002. As a result, leasing of additional LHC clinic space and recruitment for an additional PCP and support staff has been initiated. It is projected that the waiting time in LHC will meet the 30-day goal once a PCP is on board within 3-4 months.

The PCMM database is updated monthly. This database most accurately tracks veterans enrolled in primary care. Veterans are removed from this database if they have not been seen in 2 years or do not have a future appointment. This database is scrubbed based on these criteria by key Primary Care staff in Prescott.

Target completion date for actions not already completed is 1-1-03.

Medical Supply Inventory Management
Ensure that: (a) excess inventories are reduced to a 30-day supply level, (b) a physical inventory of SPD is completed, and (c) bar coding and scanning equipment are used to verify inventories.

Comments:
Concur with findings and suggestions
Current excess inventory has been reduced to approximately $30,000. Efforts will continue to reduce the excess to acceptable levels. A physical inventory of SPD is

scheduled and will be conducted on a quarterly basis. Training in proper Inventory Control Procedures has been initiated, and the SPD Lead has already attended two sessions with additional training scheduled. Internal policies relating to Inventory Control in SPD are being published/updated and will be communicated to all SPD staff. Adherence to these policies will be monitored by Clinical Care Support Line management on a regular basis. As indicated during the review, an inventory management plan is being developed that reorganizes SPD with MMO under Facilities Management. This plan includes implementation of the use of bar coding and scanning equipment to verify inventories.

Target completion date of planned actions not already completed is 1-1-03.

Quality Management
Ensure that: (a) QM activities are more consistently analyzed and tracked to resolution, and (b) physicians are more involved in QM activities and that their participation and contributions are reflected in the C&P folders.

Comments:
Concur with findings and suggestions
The Executive Leadership Office has since 1995 utilized a document to weekly track significant issues until they are resolved. Many of these are quality issues. The Quality Programs Support Line uses a similar document and process to track implementation of recommendations from Boards of Investigation, Root Cause Analyses, and external review reports.

The Performance Improvement Council (PIC) utilizes the "CRAE" format (Conclusions, Results, Action, and Evaluation/Follow-up) for reporting performance improvement activities. However, some of the documents reviewed by the IG Healthcare Inspector lacked sufficient follow-up. Therefore, the PIC will begin utilizing more run and control charts to better analyze and trend improvement data as well as emphasizing the use of a numerator and denominator for our Important Function Team measures. In addition, a tracking document will be generated monthly to track and ensure appropriate follow-up of corrective actions and will be included in the PIC minutes.

The new Chief of Staff has stressed the importance of Medical Staff involvement in performance improvement activities and has also reinforced it at a recent Medical Staff Meeting. As a result, both Medical Staff members of the Performance Improvement Council were in attendance at the June meeting. Physicians have been active participants in Root Cause Analysis teams helping to identify opportunities to improve processes related to patient safety. The Chief of Staff is also working with the Primary & Specialty Care Service Line Manager to improve the consideration of quality improvement activities during the credentialing and privileging process.

Target completion date for planned actions not already completed is 1-1-03.

Homemaker Home Health Aide Program
Ensure that: (a) complete interdisciplinary assessments are documented on all patients referred to the H/HHA program, (b) H/HHA program managers review quarterly CHA performance improvement data and patient assessment reports to determine quality of care and need for continued services, and (c) H/HHA services are obtained using existing contracts.

Comments:
Concur with findings and suggestions
The Community Program Coordinator will determine administrative eligibility for each Homemaker Home Health Aide Program request and document as a part of the referral process for each patient. The eligibility will include any applicable limitations for the provision of requested services. The Community Health Nurse Coordinator (CHNC) will work with the referring team and review the request for services to include: 1) clinical need, 2) frequency of services requested, 3) treatment plan and goals, 4) assessment plan and 5) administrative eligibility. The CHNC will review the referrals with the program/team to assure clinical and administrative appropriateness of services requested. The CHNC will provide education to facility staff about Homemaker Home Health Aide Programs.

The CHNC is developing a performance improvement plan to monitor Community Health Agency (CHA) performance. The plan will include administrative aspects of services delivered and progress towards treatment goals for individual patients. Documentation of patients with the CHA will be documented in the patient electronic

record. The treatment plan of care will be updated prior to continuation or discontinuation of services. Results of this performance improvement plan will be reported to the GEC Service Line Manager on a monthly basis.

The Homemaker Home Health Aide Program Coordinator has been instructed to only use the vendors that have purchasing agreements. The COTR will not approve any services requested for H/HHA with non-authorized vendors. The COTR and CHNC will ensure that all vendors have a purchasing agreement. The CHNC is working with the Business Office and the GEC Service Line to establish CHA contracts where appropriate.

Target completion date for planned actions not already completed is 10-1-02.

Controlled Substances Accountability
Ensure that: (a) all controlled substances in the pharmacy are verified every 72 hours, including excess, outdated, and unusable controlled substances, and that all inventory verification policies and procedures are followed; (b) excess pharmacy stock levels are reduced to a 10-day supply level; and (c) the controlled substances inspection program complies with VHA policy.

Comments:
Concur with findings and suggestions
The pharmacy instituted documented Monday, Wednesday, and Friday counts of the Pharmacy Vault by pharmacists and pharmacy technician personnel. A nationally recognized company that provides outdated narcotic drug disposal services is now used. Consequently, the "on hand" supply of outdated/excess and unusable items is greatly reduced.

It was noted that the controlled substance inventory needed to be reduced to a 10-day supply level. Ordering has been adjusted to smaller quantities and will continue until the 10-day supply level is reached.

In the process of responding to pre CAP review requests for information from review team members, the controlled substance inspection program coordinator noted deficiencies in the program. He began taking immediate action to resolve program deficiencies. These actions were noted by the team during their site visit and

included auditing the turn-ins and outdated controlled substances in the pharmacy vault, institution of dose verification utilizing CPRS, and development of a training program for inspectors.

Target completion date for planned actions not already completed is 9-1-02.

Pharmacy Security
Ensure that: (a) construction materials in the pharmacy comply with VA policy, and (b) the electronic keypads are protected to prevent observation of access codes entered by authorized pharmacy personnel.

Comments:
Concur with findings and suggestions
As noted during the review, these deficiencies will be corrected with a planned FY03/04 NRM Pharmacy Security Remodeling Project. Meanwhile, pharmacy personnel have been instructed to guard against observation of their access codes.

Target completion date is FY04.

Government Purchase Card Program
Ensure that: (a) cardholders comply with Government purchase card program policies for completing reconciliations, and (b) cardholders are instructed to comply with VHA policy limiting a single purchase to $2,500 and approving officials monitor purchasing activity to ensure cardholders comply with their authorized spending limits.

Comments:
Concur with findings and suggestions
NAVAHCS has initiated a project to correct current purchase card discrepancies and re-establish on-going compliance with A&MM regulations. The purchase card training program was evaluated and improvements have been implemented based on the evaluation. Retraining of all purchase cardholders and approving officials has begun. Training of new purchase card cardholders and approving officials will continue to be offered quarterly. These sessions also serve as ongoing refresher training. Training includes defining what constitutes inappropriate use, single

purchase limitations, splitting orders, reconciliation procedures and timeframes, reviewing reports Service/Support Line management are to use for monitoring purposes; and who to contact for information and assistance. NAVAHCS' policy on the Purchase Card Program has also been updated.

Monitors to assess compliance with the purchase card program are being established/enhanced. Several reports will be generated within the Service/Support Lines to identify discrepancies. Development of file man templates to run specific discrepancy reports is being pursued. The Purchase Card Program Coordinator will include the Service/Support Line Manager on all initial notifications of discrepancies and follow up until resolved.

Target completion date for planned actions not already completed is 9-1-02.

Information Technology Security
Ensure that: (a) ISSL establishes a policy that identifies incompatible IT duties, (b) the key personnel directory of the Contingency Disaster Plan is updated when staffing changes occur, (c) the Contingency Disaster Plan is periodically tested for effectiveness according to the plan's instructions, (d) an alternative processing site is established, and (e) systems backup data be regularly tested and stored at an off-site location.

Comments:
Concur with findings and suggestions
The Information Security Officer's position description is being reviewed and modified as needed to insure compliance with Information Security Officer roles and responsibilities. A clear delineation will be made between ISO and IT duties. A policy identifying incompatible IT duties is also being drafted.

The key personnel directory of the Contingency Disaster Plan is reviewed and updated monthly. A schedule is being developed to meet the testing requirement in the Contingency Disaster Plan. Regular documented testing of each system will be completed on an ongoing basis.

The VISN 18 Information Technical Workgroup will address alternative processing sites for all the facilities in VISN 18 and discuss testing requirements for systems

back-up data. NAVAHCS is in the process of identifying an appropriate off-site storage location for systems backup data. A procedure is being developed to check data on the backup tapes to insure it is useable.

Target completion date for planned actions not already completed is 10-1-02.

Attachment 1

Excerpt from AzHHA August 23, 2002 Weekly Newsletter

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The AzHHA Weekly Newsletter * August 23, 2002

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 Vol. 16 No. 33

Report: Arizonans on Medicare Report Trouble Finding Specialists

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Arizona is one of a handful of states where Medicare beneficiaries have reported having difficulty finding doctors, particularly specialists, who will accept new Medicare patients in the wake of a January reduction in Medicare rates for physicians, a new study says. According to the New York-based Medicare Rights Center (MRC), a nonprofit consumer advocacy group, access problems could represent a "looming emergency." MRC surveyed state directors who oversee the State Health Insurance Assistance Programs, as well as Medicare advocacy organizations that counsel people with Medicare throughout the United States. "We have seen problems, especially in rural areas," said officials with the Arizona State Health Insurance Program, according to the report. "In addition, anyone who has not seen their doctor in the past year is being considered a new patient and is told they will not be taken." Medicare cut its rates for physicians by 5.4 percent in January. However, only 1,100 of 850,000 U.S. physicians have stopped accepting Medicare coverage altogether, said MRC. Other states reporting access problems were Missouri, New Hampshire, New Jersey, New Mexico, Rhode Island, Texas, Tennessee and Virginia. To see the report, visit http://www.medicarerights.org.

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