Department of Veterans Affairs

Office of Inspector General

Review of VHA Sole-Source Contracts with Affiliated Institutions

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EXECUTIVE SUMMARY

Introduction

On February 16, 2005, the Office of Inspector General (OIG) issued Report No. 05-01318-85 titled *Evaluation of VHA Sole-Source Contracts with Medical Schools and other Affiliated Institutions.* This report detailed our collective findings on pre–award and post–award reviews of healthcare resource contracts during the period of fiscal years (FY) 2000 through 2004. In August 2006, the Secretary, Department of Veterans Affairs (VA), signed VA Directive 1663, Healthcare Resources Contracting—Buying, Title 38 U.S.C. § 8153. This Directive incorporated recommendations included in our 2005 report. The purpose of this report is to advise VA of our collective findings since VA Directive 1663 became effective, report on the effectiveness of VA Directive 1663, and make recommendations for further improvement to protect the interests of veteran patients and the Government. From October 1, 2006 (FY 2007) through September 30, 2010 (FY 2010), the VA OIG's Office of Contract Review conducted 131 pre-award reviews of healthcare resource proposals. The reviews identified $173.8 million in savings that could be achieved through contract negotiations. The $173.8 million represents 31 percent of the costs proposed by the vendors.

Results

We determined that the Veterans Health Administration (VHA) has not effectively implemented all the requirements set forth in VA Directive 1663. The primary reason for not fully and consistently implementing VA Directive 1663 is that VHA has not provided the necessary resources to the Medical Sharing Office (MSO) and the lack of training for VHA procurement and non-procurement staff. The MSO has responsibility for ensuring compliance with the requirements in Directive 1663. The MSO provides technical comments, coordinates with Patient Care Services, and grants approval for solicitations to be issued as well as final approval for contract awards. The MSO currently has a director and one analyst which, in our opinion, are insufficient to track, monitor, identify and resolve common issues; provide training; and consistently implement a nation-wide program of this magnitude.[1] In addition, VHA has not developed and provided standardized training related to sole-source contracting with affiliates and the policy requirements in VA Directive 1663. Our pre-award reviews and interactions with procurement staff consistently demonstrate that procurement

[1] In June 2011, after our report was sent to the Under Secretary for Health for comments, the MSO added three staff. VHA has also authorized additional staff as described in their action plan in Appendix A.

staff lack knowledge related to the requirements in VA Directive 1663 and healthcare contracting in general.

The lack of resources and training has resulted in the continuance of many of the same issues identified in our 2005 report. While VA Directive 1663 has resulted in some improvement, the implementation and application the Directive is not consistent nation-wide. The issues we identified are categorized into the following three areas: Contracting, Pricing, and Other.

Contracting Issues

We identified issues in the following key contracting areas:

1. Lack of Acquisition Planning.
2. Contracting Officers Cannot Fulfill Their Responsibilities.
3. Physician Time and Attendance.
4. Requirements and Duties Not Clearly Defined.
5. Pre-award Reviews Not Always Requested.
6. Interim Contracting Authority Misused.

Our pre-award reviews have shown that VHA consistently fails to adequately plan its healthcare resource contracts. The lack of planning has a negative impact on the procurement process and ultimate pricing. Adequate planning includes ensuring VA has a bona fide need for the resource, justifying the sole-source procurement, assessing the risk, and identifying and developing a backup plan for an alternate source if the need arises. Proper acquisition planning will also lend itself to the development of a clear statement of work (SOW) and identifying the responsibilities of the contractor. Poor acquisition planning is also related to our determination that interim contracting authority is misused by VHA procurement staff. The usual reason cited for using an interim contract is that there was not enough time to solicit and award a permanent contract. The failure to adequately plan the acquisition increases the need for use of interim contracts to provide uninterrupted services or to award a poorly written contract too quickly. This puts VA at a disadvantage during the negotiation process and in administering the contract. We also continue to see instances where Contracting Officers (CO) cannot perform their duties because of interference from non-procurement management officials. For example, we participated in a meeting where the Medical Center Director was clearly instructing the CO to award the contract without regard to VA policy. These actions have a significant negative effect on the procurement process as well as the ultimate prices paid by VA.

Pricing Issues

In addition to the negative affect that poor acquisition planning has on pricing, our pre-award reviews have identified common issues regarding contract pricing. VHA procurement officials continue to cite salary surveys as the basis for determining the proposed prices are fair and reasonable even when the actual salary data for the physician(s) providing the services demonstrate the proposed price and the information obtained from salary surveys are higher than the actual salary of the physician(s). VA Directive 1663 states that salary surveys should be used for market research purposes only and the awarded prices should reflect the salary and benefits of the personnel actually providing the services. In addition, affiliates routinely propose multiple physicians to fulfill a small full-time equivalent (FTE) requirement. VA Directive 1663 requires that individual rates be established by provider when multiple physicians will be performing under the contract. Notwithstanding this requirement, VHA entities routinely issue solicitations where the affiliate is only required to propose a single average rate for multiple physicians. We also continue to identify significant unsupported overhead and on-call costs proposed by the affiliates. Although there have been several instances where VHA was able to use the information provided in our pre-award reports to successfully eliminate or significantly reduce the unsupported overhead and/or on-call costs, VHA continues to award prices that include unsupported overhead and on-call costs included in the majority of proposals from affiliates.

Our pre-award reviews have shown a significant lack of compliance with the requirements contained in VA Directive 1663 for procuring healthcare services where the pricing is procedure based. VA Directive 1663 stipulates that procedure rates should not exceed the applicable Medicare rates unless there is adequate justification. However, proposed and awarded prices often exceed Medicare rates without justification. The Directive further stipulates that when services under procedure based contracts are performed at VA, the price will exclude the practice expense component (overhead) from the applicable Medicare rate for each procedure. Nonetheless, we find that proposed and awarded prices are not adjusted to exclude the practice expense component. We also found that it was common that solicitations issued by VA did not identify the applicable Current Procedure Terminology (CPT) codes or estimated quantities for each. CPT codes are the industry standard for describing the services provided by physicians. The codes were developed by the American Medical Association to record healthcare services in the United States. CPT codes are used by third party payers, including Medicare to establish rates for physician services. Therefore, absent codes and quantities for each, the CO cannot evaluate pricing or determine the value of the awarded contract. Also, without a pricing schedule showing each CPT code and awarded price, it is not possible for the Contracting Officer's Technical

Representative (COTR) or CO to certify the invoices with any level of confidence that the affiliate has billed the correct price. We conducted one post-award review of a procedure based contract and found that the affiliate did not calculate and bill VA the correct Medicare rates per the contract. Neither the VHA COTR nor the CO were aware that the affiliate was overbilling under the contract because there was no price schedule showing unit prices for each CPT code.

Other Issues

Two other areas of continued concern are conflict of interest issues and prohibited personal services contracts. Our pre-awards have identified individuals with an apparent conflict of interest that were attempting to, or in fact were, participating in the contract with the affiliate. Examples include a VA employee who worked part-time at the affiliate who was signing off and validating the procedures that the affiliate performed under the contract. In another example, a VA employee, who also was a part-time employee of the affiliate, intended to participate in the negotiation of the contract with the affiliate. These straight forward examples are troubling and indicate that VHA has not provided the necessary training concerning conflict of interest issues.

Also, in our 2005 report we recommended that VA pursue a legislative amendment that would grant VA statutory authority to award personal services contracts. Since adoption of Directive 1663, our recommendation remains the same. We believe these contracts meet the description of a personal service contract as described in Federal Acquisition Regulation (FAR) 37.101. We also have concerns that contract employees are engaged in inherently governmental functions, particularly when they are hired under contract to be the chief of the service or department.

Recommendations

We recommend that the Undersecretary for Health:

1. Evaluate and determine the resources needed by MSO to uniformly implement and monitor compliance with the requirements set forth in Directive 1663 on a nation-wide basis.
2. Develop and implement a central tracking system that captures and reports all healthcare contracting and spending with affiliates for healthcare services including interim agreements.
3. Develop and provide comprehensive standardized training for VHA contracting staff regarding sole source contracting with affiliates and the requirements of Directive 1663.

4. Develop and provide comprehensive standardized training on the requirements of VA Directive 1663 to non-procurement staff who have responsibilities relating to sole source contracting with affiliates.
5. Ensure VHA contracting staff adhere to all policy requirements contained in VA Directive 1663, including the following:
   a. Each procurement should be adequately planned.*
   b. A backup plan for an alternate source for services should be established.
   c. Contracts should be competed except where VA has established a need for services from a faculty member of the affiliate.
   d. Salary surveys should not be used to determine fair and reasonable pricing.
   e. The key personnel clause is contained in each FTE contract and properly identifies each physician.*
   f. Limiting overhead to costs directly associated with administration of the VA contract.*
   g. On-call costs are only permitted when physicians are actually compensated for being on-call.*
   h. Procedure based contracts should not be awarded at rates higher than Medicare unless clearly justified and should exclude the practice expense component when performed at VA.*
6. Develop a standard that accurately defines the expected hours and workload from one FTE for each specialty that can be applied by the contracting staff to determine the number of FTE and hours to be procured under the contract.*
7. Develop clear and well defined national standard SOWs for each specialty that can be tailored as needed to address specific procurement requirements if needed.
8. Develop and require the use of a standard pricing schedule for procedure based contracts that require the listing of all CPT codes with estimated quantities and proposed prices for each code.
9. Conduct an evaluation to determine the feasibility of using an administrator or intermediary to process billings for procedure based contracts performed at the affiliate similar to those used by Medicare administrators.
10. Develop a more robust process to ensure compliance with conflict of interest laws and regulations and their applicability to all employees, particularly Title 38 employees, who have a financial relationship with the contractor.*
11. 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.*

* A similar recommendation was made in our 2005 report.

Under Secretary for Health Comments

We provided our draft report to the Under Secretary for Health and we met with and discussed our findings and recommendations with VHA senior management. The Under Secretary provided a written response to our report on July 11, 2011. The Under Secretary concurred with our findings and with all eleven of our recommendations and provided an action plan to address the recommendations in our report. The Under Secretary noted that within the past year, the Veterans Health Administration had begun identifying some of these same concerns and had already taken action to address some of these issues. We believe the action plan is acceptable and we will follow up upon the implementation of the planned actions until they are completed.

MARK A. MYERS
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Office of Contract Review

INTRODUCTION

Purpose

On February 16, 2005, the Office of Inspector General (OIG) issued Report No. 05-01318-85 titled *Evaluation of VHA Sole-Source–Contracts with Medical Schools and other Affiliated Institutions.* The report detailed our collective findings on pre–award and post–award reviews of healthcare resource contracts during the period of fiscal years (FY) 2000 through 2004. In August 2006, the Secretary, Department of Veterans Affairs (VA), signed VA Directive 1663, Healthcare Resources Contracting—Buying, Title 38 U.S.C. § 8153. This Directive incorporated recommendations included in our report dated February 16, 2005. The purpose of this report is to advise VA of our collective findings since VA Directive 1663 became effective, report on the effectiveness of VA Directive 1663, and make recommendations for further improvement to protect the interests of veteran patients and the Government.

Background

Under its sharing authority in 38 U.S.C. § 8151–8153, the Veterans Health Administration (VHA) may enter into contracts for the purchase of healthcare resources with any healthcare provider. The law also gives VHA authority to enter 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. The purpose of the authority is to further one of VA's statutory missions, which is to conduct an education and training program for health professions. Each year over 50,000 medical students, residents, and fellows receive some or all of their clinical training in VA facilities through affiliations. VA is affiliated with 112 of the nation's 130 allopathic medical schools and 24 of the 29 osteopathic medical schools.

VA Directive 1663 requires a pre-award review by the OIG Office of Contract Review (OCR) for all sole-source proposals valued at more than $500,000. This was a continuance of VHA Directive 99-056, dated November 1999, which also required a preaward review of sole-source proposals valued at more than $500,000. Prior to 1999, preaward reviews of these proposals were conducted by another Government agency. During the period of October 2006 through September 2010 (FYs 2007 through 2010), OCR issued 131 pre-award reviews (Exhibit A). These 131 reports represent proposals valued at $555 million with $173.8 million (31 percent) in recommended cost savings. Of the 131 reports, 83 resulted in awarded contracts with sustained cost savings of $56.6 (53.8 percent)

million of the $105.3 million of the potential cost savings identified in the 83 reports. The remaining 48 contracts have not been awarded. In addition to the 131 pre-award reviews, at the request of the contracting officer (CO) we performed one post-award review of a sole source contract with an affiliate. We found that the affiliate overbilled VA over $62,000 because the affiliate did not bill according to the terms of the contract. VA collected the overcharges.

The sole-source solicitations that we reviewed fall into three primary categories: full-time equivalent (FTE) and procedure based contracts for services provided at a VA medical facility, procedure based contracts for services provided at the affiliate, and Community Based Outpatient Clinic (CBOC) contracts. VA Directive 1663 prescribes that contracts for care provided at a VA facility must be FTE based. However, a procedure based contract for services provided at VA can be awarded with approval from the Network Director that includes a written justification that demonstrates a procedure based contract is in the best interest of the Government. Procedure based contracts for services provided at the affiliate's facility are usually based on Medicare Part A (hospital costs) and Part B (physician services). Pricing for procedure based contracts for services provided at the VA facility are based on Medicare Part B only. CBOC contracts are typically based on a capitated rate—a monthly or annual fee for each enrollee.

Scope and Methodology

This report is a summary of our findings over the past 5 years of the proposals submitted for pre-award reviews and the one post-award review. These reviews include a review of the solicitation, the proposal, other contract documents, documentation submitted by the affiliates to support the proposal and discussions with contracting and other personnel in VHA and at the affiliates. This report also includes information we have obtained from our numerous contacts with VHA COs and other procurement officials who frequently contact us for assistance in preparation of a solicitation or in negotiations. In addition, we serve in an advisory capacity to the VHA Medical Sharing Committee (committee).

Our report is divided into three main topics: Contracting Issues, Pricing Issues, and Other Issues. The report structure mirrors that of the February 2005 report to facilitate a comparison of the findings and conclusions with those presented in the prior report. Relevant excerpts from the 2005 report regarding personal services contracts are included in Exhibit B.

RESULTS AND CONCLUSIONS

In August 2006, the VA Secretary signed VA Directive 1663, Healthcare Resources Contracting—Buying, Title 38 U.S.C. § 8153. This directive incorporated all of the recommendations included in our comprehensive report dated February 16, 2005, titled *Evaluation of VHA Sole-Source–Contracts with Medical Schools and other Affiliated Institutions*. Since VA Directive 1663 was issued, we have conducted a total of 131 pre-award reviews. Although VA Directive 1663 addressed most of the contractual and pricing issues that were raised in our 2005 report, we have determined that VA has not fully implemented, enforced, or consistently applied the requirements set forth in VA Directive 1663. This is of concern because many of the policies in VA Directive 1663 were not new; rather, they were contained in VA Manual M-1 Part I, Chapter 34 which was published in the 1980s.

VHA has delegated responsibility and oversight of all contracts for healthcare resources—including sole source agreements with affiliated medical institutions—to the Medical Sharing Office (MSO) which is part of the VHA Procurement and Logistics Office. Based on our reviews, interactions, and observations, we believe the MSO has not been successful in implementing the provisions of VA Directive 1663 because it has not been provided the necessary stability, resources, and support. Since VA Directive 1663 was issued in August 2006, there have been four directors of the MSO. Also, since November 2008 no staff has been assigned to the Director of the MSO with the exception of one analyst assigned as a technical reviewer who is located in Texas. The lack of stability and resources are indicators that VHA has not placed sufficient priority on implementing the Directive. Based on recent discussions with the MSO, VHA has authorized additional FTE to be assigned to the MSO office. The MSO director stated vacancy announcements have been issued to fill these positions and that these positions will be filled in the near future.[1]

Since early 2007, the OIG's OCR has served in an advisory role to the Committee. This Committee is chaired by the MSO Director and is comprised of members from various VHA organizations such as Patient Care Services, the Service Area Offices, procurement officials, and members from Academic Affiliations and General Counsel. The Committee was tasked to provide guidance on implementing Directive 1663 and address issues regarding contracting for Healthcare Resources; however, over the last couple of years the committee has increasingly been dealing with pressure from Association of American Medical Colleges (AAMC), via the Procurement and Logistic Office and VHA's Office of

[1] In June 2011, after our report was sent to the Under Secretary for Health for comments, the MSO added three staff. VHA has also authorized additional staff as described in their action plan in Appendix A.

Academic Affiliations (OAA), to not only change VA Directive 1663, but allow AAMC to actively participate in the development and writing of VA policy as it relates to sole source contracting with affiliated medical schools. AAMC is an organization that represents the interests of the affiliates. While it may be reasonable to seek input from outside organizations before developing policy, we believe it is excessive to permit the AAMC or any other organization to actively participate in writing VA procurement policy. VHA managers have done little to insulate the MSO from the demands of the AAMC and its members, whose positions also favor those of the affiliates.

Until recently, the MSO has not provided any significant training on Healthcare Contracting and VA Directive 1663 and has yet to provide routine, standardized, and comprehensive training on healthcare contracting. Based on our interactions with VHA contracting officials, it is apparent that a lack of knowledge and lack of clear guidance from the MSO is a significant issue in the area of sole source contracting in general and more specifically with compliance with VA Directive 1663. VHA managers have recognized the need for training and even concurred in an OIG audit report, *Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, Report Number 08-00477-211, issued on September 29, 2008 to develop training in this area, but have yet to provide the training. VHA has been working with the VA Acquisition Academy for a couple of years, but still has not produced the standardized comprehensive training needed by contracting and other staff. We do note that two of the three VHA Service Area Offices's recently held training for COs that addressed issues relating to healthcare resource contracting which is a good start. These facts and the fact that VHA began efforts to re-write VA Directive 1663 less than a year after it was issued indicate that implementing and complying with VA Directive 1663 has not been a high priority within VHA. As such, many of the issues raised in our 2005 report, such as contracting issues and pricing issues, have not been resolved.

A. Contracting Issues

Our 2005 report identified the following key contracting related issues with sole-source contracts with affiliates:

1. Lack of Acquisition Planning
2. Contracting Officers Cannot Fulfill their Responsibilities
3. Physician Time and Attendance Issues
4. Requirements and Duties Not Clearly Defined
5. Pre-award Reviews Not Requested

Since VA Directive 1663 became effective in August 2006, our reviews show that there continue to be deficiencies in each of these areas. While some improvement

has been made in the area of acquisition planning and physician time and attendance, there continue to be significant issues regarding COs not being able to fulfill their responsibilities and contract requirements not being clearly defined. We continue to identify sole source contracts that have not been sent in for the required pre-award review as well. In addition to these issues identified in our prior report, we have also identified an additional significant issue regarding the misuse of interim contracting authority by VHA.

1. Lack of Acquisition Planning

Our 2005 report found that none of the contract files reviewed contained any documentation that showed there was an acquisition plan. An acquisition plan demonstrates that the CO has determined the need exists and has developed an overall strategy for the procurement. An adequate acquisition plan contributes to the overall success of the procurement including the negotiations and administration of the resulting contract.

Since 2006, our reviews have shown that VHA has achieved some improvement in this area but that it still continues to be a problematic area. We selected a judgment sample of 27 contract files from the 72 pre-award reports that we issued during FYs 2008 and 2009 and conducted an in-depth review of the COs acquisition plans. The 27 contract files represented pre-award recommendations of $67.4 million.

Our review found that 12 (44 percent) of the 27 files did contain an acquisition plan; however, there was no evidence of an acquisition plan in any of the remaining 15 files (56 percent). The pre-award reviews for these 15 procurements represent $95.0 million in estimated contract value and $47.6 million (50 percent) in recommended cost savings.

Evidence suggests a correlation between the development of an acquisition plan and achieving the cost savings recommendations in the pre-award reviews. Of the 15 procurements where no acquisition plan was evident, only 50 percent of our recommended cost savings were sustained. In comparison, the sustained rate for the 12 procurements that did contain acquisition plans was about 69 percent of the recommended savings. This data suggests that the development of an acquisition plan can have a positive impact on the procurement process. We believe that the sustained rate of recommended cost savings would have been higher for the 15 procurements that did not have an acquisition plan if they had had an acquisition plan.

While the 12 solicitations that did have an acquisition plan showed a higher percent of sustained cost savings, our review of the acquisition plans identified

several common concerns. These concerns are: sole-source not properly justified, no alternate source or backup plan, and no risk assigned to the procurement.

a) <u>Sole Source Not Properly Justified</u>. VA has statutory authority, Title 38 U.S.C. § 8151–8153, to procure healthcare resources on a sole-source basis with an affiliated institution. VA Directive 1663 further states that VA must demonstrate the need for the services of a faculty member to justify a sole-source procurement with an affiliated institution. Typically, the services of an attending physician who is also a faculty member is required for resident supervision purposes when VA is a participating institution in the affiliate's accredited residency program for the particular specialty that VA is procuring under the contract. VA's participation can be verified on the Accreditation Council for Graduate Medical Education's (ACGME) website. The requirement was included in the Directive to ensure that VHA entities maximized competition to achieve fair and reasonable pricing and only issue sole-source contracts to affiliates when necessary to meet VHA's education mission.

Most acquisition plans or justifications for sole source merely stated that the vendor is an affiliate; therefore, the procurement will be sole-source. We reviewed in detail the acquisition plans for sole-source justifications for all 72 reports issued FYs 2008 and 2009 and found that none contained the justifications required by the Directive. For 33 (46 percent) of the 72 procurements, we found that VA was not a participating hospital in the residency program for the specialty being procured through a sole-source contract. In a few cases, the VA facility was a participating hospital in the primary specialty, but not the sub-specialty services that were being procured under the contract. For example, in one sole source procurement VA was a participating hospital in the affiliate's general anesthesiology residency program but not a participating hospital for the critical care subspecialty program.

Our review determined that VA was a participant in the affiliate's residency program for the remaining 39 procurements; however, the acquisition planning and justification documents did not cite the residency program as the basis for the sole-source procurement. The justification for the sole-source procurement simply stated that the vendor is an affiliate but did not document that the services of a faculty member were required. These inadequate justifications indicate that the CO did not fully comply with the policy for a sole source contract as prescribed in VA Directive 1663. We recommend that training be developed that specifically addresses the significance of VA participating in a residency program and how it relates to Directive 1663 and the sole-source justification.

b) <u>No Alternate Source or Backup Plan Developed</u>. Our detailed review of the 27 solicitations and/or acquisition plans found that there was no evidence of any

backup plan if the services required could not be procured from the affiliate at fair and reasonable prices. We believe this is a material weakness in acquisition planning and the approach taken by VHA. VHA is at an immediate disadvantage during contract negotiations if the acquisition team has not developed any alternate plans or sources for the services and the services are needed to ensure care for VA patients.

During our pre-award reviews, acquisition officials frequently told us that the services were necessary to provide patient care and that VA has nowhere else to go for the services that are being procured. While in some cases this may be true, there was little or no evidence of supporting market research and the statements appear to be generated by the program offices requesting the services. This atmosphere creates an environment where COs are unwilling or unable to make a fair and reasonable price determination and defend it—or even make a "no award" decision if necessary, because they are told patient care would be jeopardized and no backup plan or alternate sources have been developed. COs told us that they are often put in the position of awarding to the affiliate despite the fact that VHA has not conducted adequate and timely acquisition planning. Even in those cases where competition would be limited, a competitive solicitation is likely to generate more competitive pricing, even if there was only one offer.

It is critical that the CO and the acquisition team work together to develop a backup plan and an alternate source for the services that are needed. Even a temporary backup plan can have a potential positive impact on the Government's negotiation position if no long-term solution exists.

Since adoption of VA Directive 1663, we have seen two examples where VHA officials researched and identified alternate sources and in both cases achieved positive results. In the first example the VA facility was procuring radiation therapy services using a procedure based contract. The affiliate's proposed prices exceeded Medicare reimbursement rates without valid justification. The CO did not make the award. The CO re-issued the solicitation for full and open competition. In response, the affiliate submitted a proposal with rates lower than they had proposed under the sole-source solicitation. Another provider also submitted a proposal at rates lower than the affiliate. The CO awarded the contract to the provider who submitted rates lower than the affiliate. However, the affiliate filed a protest with the CO, and after review, the VHA CO and VA Office of General Counsel determined that the affiliate's protest regarding an issue unrelated to price had merit and terminated the contract with the provider. After further consideration, VA decided to re-issue a sole-source solicitation to the affiliate. The CO awarded the contract to the affiliate at prices equal to Medicare rates which represented a cost savings of $750,000 from their original proposal.

In the second example, the VA facility was negotiating with an affiliate for radiology services. When negotiations became stalemated regarding on-call costs, the CO identified another vendor who was a Service-Disabled Veteran-Owned Small Business (SDVOSB), who was able to provide the required services at fair and reasonable prices. The CO awarded the contract to this vendor. The CO cited cost savings in excess of $200,000. VA realized additional savings because after one year with the SDVOSB contractor, the VA facility hired a radiologist who now performs the radiology services as a VA employee.

These two examples, one where the affiliate ended up with the contract and one where they did not, demonstrate the importance of developing an alternative or backup plan to ensure the Government pays fair and reasonable prices for the services being procured. In both cases, the COs received support from management to pursue an alternative source. However, we often find that VA contracting officials get little to no support and even resistance from VA management to develop alternate sources for the service being procured from the affiliate. This lack of support leads to COs being prevented from fulfilling their duties and responsibilities, which is discussed later in this report. We recommend that training be provided in this area and that VHA require alternate source plans be established for each sole-source procurement as required by Directive 1663.

c) No Assigned Risk. Sole-source contracting inherently has more risk than full and open competition. Risk relates to both the cost of the services or products as well as the quality and performance under the contract. The assessment of risk is important because it helps direct the course of the acquisition process and highlights the potential issue areas so that VA officials can take the necessary steps to reduce and manage the identified risk. Federal Acquisition Regulation (FAR) 7.105 states that the acquisition plan should discuss technical, cost, and schedule risks.

Our review of the 12 procurements in FYs 2007 and 2008 that contained acquisition plans showed that the assigned risk for 10 of the plans was “none.” Of the two plans that addressed risk, only one identified any legitimate risk. The CO recognized that there was a risk that the workload could decrease below the estimates resulting in an actual FTE requirement that would be less than the contracted FTE level; therefore, there was a risk that VA could overpay for services. The second acquisition plan that addressed risk merely stated that if there was no award, VA would not be able to care for patients. This statement generally fits the approach taken in most of the sole-source procurements that we have reviewed—that the award has to be made regardless of cost because of patient care issues and there are no other alternative sources; therefore, the only risk that exists is if VA does not make an award.

If risks are not identified, VHA acquisition officials and management cannot take the steps necessary to mitigate and reduce the risk to VA and thus protect VA's interests. It is not only important to identify the risks, but also to plan accordingly to reduce those risks.

2. Contracting Officers Cannot Fulfill Their Responsibilities.

In our 2005 report, we stated that COs were impeded in the performance of their duties by program and non-procurement management officials. FAR 1.602 states that only the Government CO can bind the Government in a contract and that they have the responsibility to ensure all laws, executive orders, regulations and all other applicable procedures, including clearances and approvals are followed. They are also tasked to ensure that the affiliate complies with all terms of the contract and to safeguard the interest of the Government in its contractual relationships.

Our reviews of sole-source procurements with affiliates show that this problem continues to be a significant issue. We have observed specific examples where the CO was impeded in three primary areas: 1) the requesting service did not adequately define and/or provide support for the requirements; 2) VHA management did not provide the necessary support to comply with the requirements of Directive 1663; and, 3) VA officials provided assistance to the affiliate with their proposal including the proposed costs and during negotiations.

a) Requirements Not Defined. We have consistently noted in our reports that solicitations do not contain accurate estimates for the requirements—especially for procedure based contracts. Of the 30 procedure based proposals we reviewed in FYs 2008 and 2009, only 12 (40 percent) included an accurate listing of Current Procedural Terminology (CPT) codes and estimated quantities. The remaining 18 (60 percent) did not identify which CPT codes VA needed and/or the estimated quantities for each. When we requested that the CPT codes be identified as well as the estimated quantities, the typical response from COs was that it was too time consuming or too difficult to do. CPT codes and estimated quantities are necessary to establish pricing, obligate funds for the services, and properly administer the contract. It is the responsibility of the program office requesting the services to provide the requirements to the contracting entity.

As one example, a procedure based solicitation that included services for multiple specialties simply contained a 62-page listing of every possible CPT code without any defined quantities. VA resisted our requests to identify which CPT codes were expected to be used and the estimated quantities for each citing that there were too many CPT codes involved. Eventually, we were provided with the CPT codes and estimated quantities expected to comprise over 80 percent of the

contract billings. Because the affiliate was not provided estimated quantities in the solicitation, there was a considerable discrepancy between the costs proposed by the affiliate and the recommended costs in the OIG pre-award report. As a result, the CO encountered significant and unnecessary difficulties during negotiations because the affiliate proposal and OIG's recommended costs were not based on the same numbers. Because of the confusion created by the discrepancies and other issues, a long term contract award was not awarded. Nonetheless, from September 2009, when we issued our report, VA continued to purchase services from the affiliate using purchase orders. Then on April 1, 2010, the facility began using interim contracts. VA plans to hire physicians by July 2011 to handle the patient workload and use the affiliate for fill-in purposes only. The use of purchase orders and interim contracts for this period of time is inconsistent with longstanding VA policy.

For FTE based contracts, we continue to identify issues concerning the level of FTE required by VHA to provide the services. VHA has not provided any guidance to contracting or program officials regarding how to define an FTE for contracting purposes. For Title 38 employees, VHA defines an FTE as simply 2,080 hours per year. VHA uses the same number when contracting for healthcare resources which causes problems because the 2,080 hours does not take into consideration paid time-off for annual or sick leave, holidays, training, etc.—all of which need to be taken into consideration when determining the level of effort needed to provide the required services. For example, a solicitation states that 1.0 FTE is required but VHA expects services to be provided every week day of the year, regardless of administrative leave or other paid time-off. This results in a discrepancy between the FTE requirement in the solicitation and the level of FTE actually needed by VHA and proposed by the affiliate.

We also have found that regardless of the FTE requirement, affiliates often propose a list of multiple physicians who can or will fulfill the requirement on less than a full-time basis. In other words, the affiliate may propose two or more physicians to fulfill a requirement for 1.0 FTE. In these cases, the affiliate proposes an hourly rate for each hour worked under the contract. However, the physicians providing the services under the contract also provide services to the affiliate. We have found that VA typically does not take into consideration the hours that a physician actually provides to an affiliate to obtain the agreed-upon salary and benefits, which potentially results in VA overpaying for services. For example, it is routine for physicians in many specialties to work more than 40 hours per week. Their fixed salary and benefits packages are based on the total number of hours required to provide services, not a 40 hour work week. If VA has a need for a physician for 20 hours per week, VA normally will define that as 0.5 FTE requirement. If the physician routinely works 60 hours per week (20 at VA and 40 at the affiliate), that physician is not spending half his time at VA, but only

a third of his time. In these situations to avoid overpaying, VA needs to ensure that VA pays for a third, as opposed to half of this physician's direct expenses.

b) Lack of Support from VHA Management. We believe that COs generally do not have the full support from local VHA management in the negotiation and award, or no award, of sole-source contracts with affiliates. Our general observation is that local VHA managers are not supportive of the acquisition process as defined in VA Directive 1663. We have observed specific instances during the pre-award reviews, negotiation, and general assistance to COs where VHA managers took action that undermined the CO's efforts.

In one example, we were providing assistance to the CO during negotiations between VA and an affiliate for radiology services. Senior VHA management also took part in the negotiations including the Medical Center Director. In the negotiation meeting with the affiliate, the medical center director questioned decisions that the CO had made during the acquisition process including what his negotiation objectives were or should be. The Medical Center Director's actions clearly undermined the CO's authority and ability to do his job and demonstrated to the affiliate that local managers were not supporting the acquisition staff or the process.

As another example, a CO had organized a VA only meeting to discuss certain issues surrounding a sole-source solicitation to be issued to an affiliate. The CO's intent was to ensure that he was following all the requirements of VA policy including VA Directive 1663. He specifically had questions regarding the level of effort needed to meet the facilities requirements for the solicitation. Prior to the meeting, the CO had been trying, unsuccessfully, to identify the facilities workload, which should have been done by the program office requesting the services. Senior VA management, who participated in the conference call, included the Medical Center Director and the Veterans Integrated Service Network (VISN) Director. The Medical Center Director made it clear that he was not concerned with the nuances of VA policy nor did he give any legitimacy to the CO's questions concerning what VA's exact requirements were. He specifically stated that he just wanted the procurement pushed through and completed quickly even though the CO still had fundamental questions regarding the procurement. These and other statements by the Medical Center Director clearly showed that he was not concerned with ensuring that the contract was awarded properly or that VA paid fair and reasonable prices for the services rendered.

Based on our experiences, including numerous discussions with CO's and other procurement officials, we believe these examples are not exceptions, but may be commonplace in many VHA procurement offices. We have not only observed instances of VA managers not providing adequate support to the acquisition staff,

but have also observed them providing support to their affiliate in direct contradiction to the efforts of the VHA procurement staff.

c) <u>VA Officials Provide Inappropriate Support to Affiliates</u>. Through our reviews we have found procurements in which VA officials have provided significant support to affiliates regarding their proposals and even proposed costs. There have also been instances of discussions between VA managers and officials representing the affiliate without the presence of the CO that are borderline negotiations, if not outright negotiations. This type of interaction between VA officials and the affiliate impinges upon the CO's ability to perform their duties because the affiliates construe the assistance and discussions with non-acquisition VA officials as negotiations or at least agreement to what the basis of their proposal should be—including the basis for the proposed costs. Two of the most significant examples below illustrate this finding.

During a site visit to an affiliate during a pre-award review of a proposal for orthopedic services, we determined that officials at the affiliate could not adequately support their proposed costs. We learned they had not completely read the solicitation and were not familiar with all of the requirements. When we further questioned the officials at the affiliate, we learned that a VA official representing VA management was directing the affiliate regarding what costs they should propose and that the CO had not been involved in these discussions. We determined that the proposed costs were significantly overstated. Our report questioned $1.5 million (48 percent) of the $3.1 million in proposed costs. VA ended up cancelling the solicitation and reissued a new solicitation for orthopedic services.

In the second instance, we conducted reviews of several proposals submitted by an affiliate for contracts for multiple specialties where the VISN had appointed an individual to act as a liaison officer between the affiliate and VA. During the course of the review, we found that the proposed costs were actually developed by the VHA liaison officer. When OIG auditors questioned the liaison officer about her involvement, she actually used the word "negotiation" several times to describe her interactions with the affiliate. She told us that the nature of the discussions included how the services would be procured, how the schedule of services would be constructed, and what percentage of Medicare reimbursement rates would be appropriate. The VHA liaison officer also stated that she calculated and provided rates to the affiliate. Our review found that the affiliate submitted the numbers given them by the VHA liaison officer to the VHA CO with their proposal.

These examples illustrate how difficult, and even impossible, it is for a CO to negotiate a contract when VHA officials have already had discussions and even

negotiations with the affiliate concerning the requirements, terms and conditions, and even prices. These actions lead the affiliate to believe it has an agreement on costs since the numbers came from VA and the net result is that the CO is debating the numbers with other VA officials and not the affiliate. During the pre-award review, the affiliate cannot adequately support their proposal because they have not actually developed the costs.

We recommend that standardized training be developed for non-contracting VA officials who have involvement in the acquisition process. The training should educate officials on the general acquisition process and focus on the roles and responsibilities of contracting and non-contracting staff and common issues as they relate to sole-source contracting with affiliates.

3. Physician Time and Attendance.

All FTE contracts, regardless of the unit of payment (monthly, weekly, daily, or hourly), should require the affiliate and VA to maintain a system of tracking physician time and attendance, but particularly so when the unit of payment is hourly. It is even more critical when the contracted services are provided by providers who are also part-time VA employees. The only way that VA can certify that the services have been received is to be able compare the invoice from the affiliate to some authoritative record such as sign in/out sheets. We reviewed all FTE based procurements for FYs 2008 and 2009 and found that 33 of the 42 FTE procurements required physician time and attendance record keeping.

While we did not review the actual administration of the time sheets for these solicitations, we believe the record keeping as described in the solicitation is adequate, if implemented and managed correctly. During our site visits we have received feedback from contracted physicians that they feel that this process is a burden and that it detracts from patient care. However, when asked, they were unable to provide any support for their complaint that time and attendance record keeping is burdensome or that it detracts from or jeopardizes patient care. The only concrete explanation we received was from an affiliate was that physicians were uncomfortable with sign in and out sheets because they were concerned about any potential fraud investigation regarding time and attendance. Such a position makes little sense if physicians are accurately recording their sign in and out times and would only be of concern if the physicians were in fact falsifying time keeping entries.

4. Requirements and Duties Not Clearly Defined.

Through our reviews, we continue to regularly find and cite deficiencies with the statement of work (SOW) where the requirements and duties are not clearly

defined or there are vague, conflicting, and undefined statements regarding the requirements or duties. Although the solicitations undergo a legal and a technical review, these reviews appear to be insufficient with regard to substantive issues such as the sufficiency of the requirements. These issues are important for VHA to hold affiliates accountable. Some examples are as follows.

- A SOW for radiology services required the affiliate to "review consultations of procedures under this contract" and be responsible for "monitoring or performing and interpreting of aforementioned procedures." As noted in our report to the CO, these statements were vague as to whether the affiliate was to be reviewing consultations, conducting consultations, and whether they were to monitor or perform the procedures.
- A SOW for implantation of Ventricle Assist Devices (VAD), was not clear on whether the VAD device was included or not included in the price.
- A SOW for an FTE based procurement to provide backup services when VA cardiologists are on leave or travel, used the term "per-procedure" in the SOW, but a list of procedures or estimated quantities were excluded. However, the SOW included a schedule of services broken out to a "fixed monthly" cost and an "as needed" cost, which was not only inconsistent with a "per-procedure" requirement, it was inconsistent with the basic requirement to provide backup services on an intermittent, as needed basis. The schedule of services and SOW were confusing as to exactly what was being procured and how VA intended to pay for the services.
- A SOW for orthopedic services indicated that VA intended to procure the services at a daily rate. We found that the SOW had conflicting times when the physician was expected to be present and there was no clause or other provision that allowed VA to adjust payment if the physician was not present the entire day.
- Another SOW stated the physician work hours were 8:00 a.m. to 4:30 p.m. Monday through Friday, which was inconsistent with the solicitation's estimated requirement of only 0.6 FTE.
- A SOW for gynecological services, did not specify any work hours when the contract physicians were to be present nor did it list any major duties to be performed under the contract.
- A SOW for anesthesiology services required the affiliate to provide a physician who was to be dedicated to VA for the day. This was inconsistent with a provision in the statement of work that expressly allowed the physician to leave VA if his "duties" are complete.
- A SOW for radiology services that identified a Relative Value Unit (RVU) as the reimbursable unit for payment included an estimate for services ranging from 30,000 to 70,000 RVUs. This wide range is indicative of a

failure by the medical facility to adequately define the requirements and the affiliate to hire sufficient personnel to provide the services.

- The schedule of services in a solicitation for an FTE based contract for urology services estimated the FTE requirement between 1.6 to 2.7 FTE, which in and of itself is a large discrepancy making it difficult for the affiliate to meet the requirement. However, the discrepancy was even more significant because we also found that another part of the same solicitation stated the FTE requirement was between 0.5 to 1.8 FTE.
- A SOW for anesthesiology services included research duties as part of the requirements. However, the nature of the research was not specified, there was no defined time spent in research, and the language also permitted the research to be off VA premises, eliminating any monitoring or approval by VA.

Where appropriate, we recommend that standardized SOWs or templates be established for each specialty that VA contracts for. The templates should be developed so that certain portions are standardized and other portions will require input to tailor it to the unique needs of each procurement.

5. Pre-award Reviews Not Always Requested.

Directive 1663 requires all sole source healthcare resource proposals valued at $500,000 or more to have a pre-award audit conducted by the OIG. Once the OIG completes its review the CO can finalize negotiation objectives and commence negotiations with the affiliate. When the timing of healthcare services is a compelling urgency that the contract is awarded without a pre-award audit, the directive requires the OIG to perform a post-award audit.

It is difficult to get complete visibility on whether all sole source procurements over $500,000 are being sent in for a pre-award review because VHA has no reliable data source that identifies all sole source procurements. All healthcare resource solicitations are also supposed to be submitted to the MSO prior to issuing the solicitation and prior to final award. The MSO has historically maintained a log of all solicitations received. We obtained a copy of the log from the MSO for FYs 2007 through 2010. This list had a total of 178 unique sole source procurements equal to or greater than $500,000. We found that 118 (66 percent) of these proposals were not sent in for pre-award review. The majority of the 118 proposals resulted in contract awards. Without an analysis of the support for the proposed costs, procurement officials have little to rely on except past prices, FSS prices, or salary surveys—all of which are unreliable and not intended to support a decision that the proposed pricing from an affiliate for a sole-source procurement is fair and reasonable.

Incidentally, we also found that 71 of 131 proposals submitted to the OIG for pre-award review during the same period were not on the MSO's log of sole-source procurements. This further highlights the fact that the database is not reliable because proposals are not being submitted to the MSO as required by policy.

In addition, we also requested a listing of awarded healthcare service contracts from six VISNs that submitted no or a minimal number of audit requests to identify any sole-source awards equal to or greater than $500,000 that were not submitted for review. We received a response from four of the six and found only one instance of non-compliance for one of the VISNs. The contract award value was $650,000 and was for anesthesiology services. This sole-source contract was not submitted to the OIG for the required pre-award review. Our review of the contract in VA's electronic contract management system (eCMS) found that it was incorrectly categorized as a competitive award.

We also ran several other queries in eCMS; however, there is no single authoritative report to extract sole-source procurements with affiliates. It is very difficult to browse contracts and types of contracts in eCMS. However, in running various reports in eCMS and reviewing contract documents we found three additional sole-source awards equal to or greater than $500,000 that should have been submitted for pre-awards. For one of the sole source contracts it was even questionable whether it was a healthcare related service. It was valued at $3.5 million and was awarded to a university that had no medical school and was for medical engineering consulting services. The contract appears to be outside the scope of § 8153 authority. The same VISN awarded another sole-source contract valued at $3.0 million to an affiliate for radiation therapy services without the required OIG pre-award review. The third example we identified in eCMS was a sole source award for heart transplant services that was not submitted for a pre-award review as required. The value of this contract was $2.5 million.

6. <u>Interim Contracting Authority Misused</u>.

Directive 1663 authorizes interim contracts to provide required health care resources on an emergency basis for short-term needs, or as an interim measure to complete the contracting cycle for long term agreement. Under the interim contract authority, the CO is allowed to enter interim contracts of up to 180 days. Additional time can be approved in emergency situation on an exception basis but not to exceed one year.

We determined that VHA has no reliable data on interim contracting authority—when it is used and more important why it is being used. Our reviews have shown most of the time interim contracts are used with the reason stated as "urgent" or "emergency" without further explanation or support for the urgent or emergency

nature of the situation or that patient care would be jeopardized if services are not continued. However, we have found that in most instances, interim contracting is being used because VA has not adequately planned ahead and/or started the acquisition process in a timely manner. The need for the types of services being procured is typically known well in advance and is not an unexpected or unanticipated requirement, especially when the services have been provided through contract for one or more years.

We attempted to use eCMS to identify interim contracts by extracting healthcare contracts with effective contract dates less than one year in length for FYs 2008 and 2009. Through this process, we identified 107 interim contracts. We requested the documentation for all 107 contracts and received responses for 70 (65 percent). We did not receive any response to our request for information on the remaining 37 contracts. Our review of these 70 interim contracts found that 10 (14 percent) had durations that exceeded one year. The length of these 10 contracts ranged from 13 months to 30 months. In the case of a neurosurgery services interim contract with a VA affiliate, the CO issued two six month interim contracts as permitted by Directive 1663. However, the CO inappropriately extended the interim contract for an additional six months under contract clause FAR 52-217-8, Option to Extend Services, and disregarded Directive 1663's interim contract authority.

Another CO issued interim contracts for surgery and radiology healthcare services that were in effect for 30 months. The CO explained that the interim contracts were extended beyond one year because of the inability to award permanent healthcare service contracts. They explained that the delays were associated with not having the CO directly involved in the acquisition planning phase and the inability of the affiliate and the VA Medical Center's (VAMC) to resolve disagreements over the terms of a permanent healthcare services contract.

We also identified a couple of other "long-term" interim contracts that did not appear on our queries from the eCMS system. Our review of these interims showed that the affiliate typically requested and received a price increase every six months. One of the most egregious examples is an interim agreement that continued for more than five years for brachytherapy services. A detailed analysis of our findings regarding this interim contract is contained in an OIG report issued on May 3, 2010, *Healthcare Inspection Review of Brachytherapy Treatment of Prostate Cancer, Philadelphia, Pennsylvania and Other VA Medical Centers.* This interim contract was awarded after the affiliate had submitted a proposal in response to a solicitation for a long term contract. Although the pre-award report was issued to the CO just shortly after the 6-month interim contract should have expired, the contract was never negotiated. Instead, the CO continued to improperly extend the interim contract. When we questioned VA officials as well

as officials from the affiliate, no one was able to provide any concrete reason or explanation. There was no documentation of negotiation of prices or any determination that the prices were fair and reasonable. We also found that the CO approved significant price increases during the 5-year time period without any justification despite information in the pre-award report identifying fair and reasonable prices for the services.

As another example, a VAMC needed radiology services from an affiliate, but had to award interim agreements for two years before a permanent healthcare service contract was awarded. The CO cited that they did not consider the steps and time involved with awarding a permanent healthcare service contract and were compelled to procure the services on an interim basis.

We recommend that VHA develop and implement a tracking and monitoring system that gives complete visibility of all sole-source contracts and spending with affiliated institutions. This information is needed by VHA to ensure compliance with Directive 1663.

B. Pricing Issues

Our prior report identified several key issues regarding the awarded pricing for sole-source contracts with affiliates:

FTE Contracts

1. Use of National Salary Databases
2. Identification of Key Personnel
3. Overhead Costs
4. On-Call Costs
5. Profit

Procedure Contracts

1. Cost Exceeded Medicare Reimbursement
2. Rates Not Properly Calculated
3. Combination of FTE and Procedure Based in One Contract

1. FTE Contracts Pricing Issues

a) Use of National Salary Database. A significant finding regarding pricing in our 2005 report was that many COs were relying on the AAMC national salary database for medical college faculty to determine that proposed pricing was fair and reasonable. The 2005 review documented that it was common practice and even policy that VA used the salary database at the 75 percentile to determine

whether the proposed costs were fair and reasonable. The 2005 review found that the information in the database was not a reliable source of information on which to base fair and reasonable price determinations. We noted that in many instances the 75 percentile exceeded the costs proposed by the affiliates, which resulted in VA overpaying for the services. VA Directive 1663 requires that VA use actual direct costs to determine if proposed pricing is fair and reasonable. As stated in Directive 1663, salary surveys should be used only for conducting initial research and establishing the Independent Government Cost Estimate and to ensure that the affiliate's actual costs are within acceptable limits.

Based on our review of Price Negotiation Memorandums (PNMs), we continue to see examples where COs cite salary surveys as the primary basis for determining proposed prices are fair and reasonable. As one example, an affiliate included a 26 percent overhead rate in their proposed salary amounts and $1,200 per day in on-call costs to provide neurosurgery services to VA. The OIG pre-award review determined these costs were not supported and recommended the CO not include them. The pre-award review determined the actual costs incurred by the affiliate to provide the services and recommended pricing that would result in saving of $3.8 million (62 percent) of the $6.2 million costs proposed by the affiliate to provide 1.28 FTE over a four-year period. A post-award review of the contract showed that the CO did not sustain any of the recommended cost savings because she relied on salary and market surveys to determine the offered prices—even though they included unsupported overhead and on-call costs—were fair and reasonable.

In another example, VA paid $300,000 more than actual costs for radiotherapy services because they used salary surveys to determine prices were fair and reasonable. In fact, the OIG review determined that the affiliate's proposed prices for radiotherapists were based on salary surveys and not actual costs. We reviewed payroll and other records and found that the proposed costs exceeded the affiliate's actual costs by $300,000. However, based on the salary survey, the VA CO determined the prices were fair and reasonable and awarded prices based on the salary survey.

Salary surveys do not necessarily reflect all the factors, such as subspecialties, faculty position, experience, and credentials, that are needed to establish whether proposed prices are fair and reasonable. VA Directive 1663 states that the use of salary surveys should be limited to market research but the contract should reflect the actual salary and benefits of the personnel providing the services. The actual salaries and benefits should be compared to the market survey for the purposes of ensuring that the actual costs are within reason and are not significantly higher than the market survey. This approach is not new; it has been a long standing VA policy that predates VA Directive 1663 by more than a decade. However, the

common use of salary survey information is to make fair and reasonable determinations regarding the proposed prices—even when those prices exceed the affiliate's actual direct costs. We recommend that VHA contracting staff be trained in the proper use of salary surveys and ensure salary surveys are not used as the basis for determining the proposed prices are fair and reasonable.

b) Identification of Key Personnel. VA Directive 1663 mandates that all FTE based contract solicitations require the offeror to identify key personnel proposed to provide the required services and their qualifications.

We reviewed the SOWs for 49 FTE based solicitations' to determine if key personnel were identified. We found that 38 (78 percent) of the 49 required the contractor to identify the physicians who were to provide services under the contract. We did not find any reference to key personnel for the remaining 11 solicitations. These findings show a significant improvement since our prior report.

Identifying the key personnel is not only important for privileging purposes but also important in establishing fair and reasonable prices. It is common for an affiliate to identify multiple physicians and even an entire pool of physicians who will provide services to VA—even when the FTE requirement is small or just a partial FTE. In many of our reviews we have found significant variances in salaries. We have seen differences as high as $230,000 in the annual salary of the lowest paid physician compared to the highest paid physician. It is important that VA knows how many physicians will be providing services at VA for pricing purposes because if an affiliate is proposing numerous physicians with differing salaries, then VA will need to establish individual rates for each physician to protect the Government's interests. This is to eliminate the risk that an affiliate can include high paid physicians to increase the average hourly rate but yet, because they control who will actually work at VA, send over the physicians who receive lower compensation packages.

c) Overhead Costs. For FTE-based contracts, general department or university overhead and other indirect costs are unallowable under Directive 1663. VA's policy of not paying general overhead, but only costs directly associated with administering the contract was not a new policy under Directive 1663. This was the policy of VA in the previous policy document VA Manual M-1, Part I—Medical Administration Activities, Chapter 34—Medical Sharing. Chapter 34 stated that the "primary principle should be for VA to reimburse the affiliate for all expenses *associated* with the contract." Another section of Chapter 34 stated that "there is little or no administrative overhead" because the fact that VA is a single payer and pays the full price—there are no co-pays and deductibles to collect from patients and no bad debt to write-off.

Disallowing overhead is consistent with 38 U.S.C. § 7409 which allows VA to use cost reimbursement type contracts. VA would only reimburse the affiliate for those costs actually incurred to provide services under the contract. Our reviews have consistently found that most of the overhead costs proposed by affiliates are not applicable to the VA contract. These usually come in one of three different forms: university overhead, department overhead, or a Dean's Tax. While an education component exists between VA and the affiliates, the main reason for the healthcare contracts for physician services is VA's simple need for physician services. There is a bona fide need for clinical services from a physician to provide patient care services. As such, the general university overhead rate is non-applicable to the contract. Our reviews regarding department overhead have consistently found that the department overhead rates are non-applicable to the VA contract because the university department at issue is typically a clinical department. That is, the department at the university exists to provide medical care to their patient population. Therefore, the overhead costs of the department exist and directly relate to providing medical care to their own patients at their own clinic or facility. VA is incurring the same clinical overhead expenses in the operation of their own clinical department. Lastly, the Dean's Tax is similar to a university overhead rate and relates to predominantly indirect education costs of running a university and not providing clinical services at VA.

From our pre-award reviews of 41 FTE-based contracts, we found that 29 (71 percent) included overhead costs. Of the 29 proposals with overhead, the OIG did not question overhead costs for only three contracts. For eight reviews, the OIG allowed some indirect costs because the affiliate provided support that those specific overhead cost components were related to the physician's work at VA. We disallowed overhead costs in the remaining 17 reviews.

Our review of contract awards for the 30-month period ending May 2010 found that VA COs sustained approximately 48 percent of our recommended cost savings regarding overhead. The only basis and support that the COs had available to them to negotiate the proposed overhead costs completely away or downward has been the OIG pre-award reports. A few of the positive examples where VA was able to significantly reduce the proposed overhead costs are:

- An affiliate proposed $1.4 million in overhead costs to provide ophthalmology services to VA. The OIG report questioned *all* proposed costs because the affiliate could not provide any detail or support for the costs. During negotiations the CO made it clear that only overhead costs that are related to the VA contract would be allowed. The affiliate provided additional documentation during negotiations upon which the CO awarded only $348,000 in overhead costs as opposed to the proposed $1.4 million.

- An affiliate proposed $247,763 in overhead costs to provide ophthalmology services to VA. Our review questioned $117,763 of the proposed costs and recommended overhead costs related to administration of the VA contract not to exceed $130,000. The VHA CO used our report and negotiated the overhead costs down to $130,000.
- An affiliate proposed $184,375 in overhead costs to provide Medical Officer of the Day services. The affiliate failed to support any administrative costs during the pre-award review; therefore, the OIG report questioned all of the proposed overhead costs. The CO was able to negotiate the proposed costs down to $27,295 after she made the affiliate quantify the administrative work related to providing services at VA.

Based on our review of PNMs, we determined the majority of the sole-source contracts awarded to affiliates contain unsupported overhead costs. The table below is a simple snapshot for contracts awarded in 2009 that contained proposed overhead. While the average sustained rate is approximately 48 percent when looking at a larger period of time, that percent is skewed by some high dollar procurements where VA has had some success in reducing the overhead costs. The reality is that the data shown in the table is representative of the typical contract that contains proposed overhead. The table shows that for the majority of sole-source contract awarded to affiliates, VA allows overhead when proposed by an affiliate without any justification. We believe this is related to the issues discussed in Section A of this report concerning VA officials providing inappropriate support to affiliates.

Overhead Costs for Awarded Contracts that Contained Proposed Overhead
2009

	Proposed Overhead Costs	OIG Recommended Overhead Costs	Awarded Overhead Costs
1	60,000	0	60,000
2	297,384	0	191,478
3	89,600	0	0
4	12,076	0	3,180
5	184,375	0	27,295
6	15,257	7,000	15,257
7	84,240	0	84,240
8	453,624	365,937	453,624
9	209,686	0	209,686

It has been suggested that VA accept the overhead rates accepted by Medicare and other payees. This would be acceptable if the services were being provided at the affiliate. However, when services are provided at a VA facility, those costs are not incurred by the affiliate. In fact, if VA was to pay this level of overhead, it would be paying twice because VA is incurring similar costs to operate the facility where the services are being provided.

We recommend that VHA enforce the provision in VA Directive 1663 that prohibits general overhead costs. The only overhead costs that should be allowed are those administrative costs that are directly related to providing services to VA under the contract.

d) On-Call Costs. Directive 1663 stipulates that on-call costs should not be separately broken out unless the physician(s) obtains separate on-call pay from the affiliate. Unsupported on-call costs account for a significant amount of the recommended savings identified in our pre-award reviews. Our reviews of proposals with on-call costs have found that in the majority of these cases the physicians did not receive separate on-call compensation and the affiliate was unable to demonstrate any additional costs incurred to provide on-call services under the contract. In reality, profit to the affiliate was disguised as charges for on-call services.

We analyzed all the awarded contracts for which we conducted a pre-award review in FYs 2008 through 2010. There were a total of 57 awards made. Twelve of the proposals for the 57 awards contained on-call costs of $12.7 million in total. The OIG pre-award reviews for these 12 proposals recommended only $565,000 in on-call costs ($12.1 million in potential cost savings). Our reviews found that the overwhelming majority of the proposed costs for on-call coverage were not supported by actual costs. The OIG pre-award reviews determined that most salary agreements explicitly stated that the salary paid to the physician by the affiliate is inclusive of on-call compensation—no additional compensation for required on-call work. Discussions with one affiliate found that on a rare occasion they do hire physicians and agree that the physician will not have to serve call time. In this situation, the salary will be lower for that physician because the normal salary includes compensation for the on-call hours that a physician has to provide. However, this affiliate and others want to charge VA for any on-call coverage provided to VA. When VA agrees to pay additional on-call costs for physicians who receive a salary that is inclusive of on-call compensation, then VA is essentially paying twice—paying a portion or all of a physicians' salary that is reflective and inclusive of on-call hours and then paying additional costs for on-call hours. There were instances where the OIG did in fact recommended on-call costs be included for a total of $565,000. In those instances, the affiliate demonstrated they actually paid additional compensation to physicians when they

worked a call shift. Our review of the PNMs for these 12 proposals found that the CO sustained $9.8 million, or 80 percent of the recommended savings; however, VA still awarded $2.9 million in unsupported on-call costs.

In awards where VA was able to sustain significant savings, the only data and information the COs had to refute and negotiate away the on-call costs was the information and analysis contained in the pre-award review done by the OIG. Two of the most significant examples of success were proposals for ophthalmology services.

In the first example, our review determined that the affiliate proposed $560,000 per year to provide on-call services. The contract was for a base year and four 1-year options for a total of five years. This represented a total of $2.8 million in proposed on-call costs. Upon review of all the physician salary agreements and the on-call policy of the affiliate, we determined that the physicians' salaries were inclusive of any on-call work—no additional compensation was provided for on-call hours. During negotiations the CO clearly informed the affiliate that the proposed costs were not only unreasonable, but unsupported by actual costs. The CO outlined the requirements in VA Directive 1663 and articulated which costs were supported by actual costs and what VA's negotiation objective was. The affiliate agreed to remove the proposed on-call costs as well as about $250,000 thousand in unsupported overhead costs. The CO did agree to an 18 percent profit (about $650,000), but sustained overall about $3.1 million in savings on on-call and overhead costs. VA Directive 1663 does allow profit but discourages it and requires that it be a separate line item, which was the outcome in this case.

In our second example, we questioned all of the $1.9 million for the proposed on-call costs for an Ophthalmology services contract. Because the affiliate's ophthalmologists are not provided on-call pay as part of their salary, we disallowed the proposed on-call costs as required under VA Directive 1663. The CO also was successful in disallowing the proposed on-call costs during negotiations. As stated earlier, the only information that the CO had to support her negotiation objectives was the information and analysis in our audit report.

While there are some positive examples where VA has eliminated or reduced unsupported on-call costs, VHA has awarded unsupported on-call costs for numerous contracts. For example, in our review of a proposal for radiology services, we questioned the affiliate's proposed on-call costs. Subsequently, the contract was not awarded because the affiliate refused to provide services without being compensated for on-call services. The solicitation was later amended requiring an all inclusive firm priced for each procedure. The affiliate revised proposal included their estimated 23.3 percent above their calculated per procedure costs as compensation for on-call availability requirements. During our

follow-up review, the affiliate refused to provide us documentation to evaluate their proposed 23.3 percent on-call rate. As stated in VA Directive 1663, on-call costs are allowed if the providers are actually paid additional for on-call services and the prices are negotiated as a separate line item and not part as an all inclusive rate. Therefore, we questioned $1.2 million pertaining to the affiliate's proposed 23.3 percent on-call rate. The CO attempted to negotiate the contract and requested the affiliate provide documentation to support on call compensation. Although the CO acknowledged our findings, the contract was awarded simply because VA lacked any other options for radiology services.

As a third example, an affiliate proposed $1,200 per day for on-call services in their offer to provide Neurological Surgery services. We questioned $1,752,000 in proposed on-call costs because we found that the affiliate did not have a policy requiring them to pay their physicians additional pay for on-call coverage nor did the physician's employee agreement letters require additional pay for on-call coverage. Despite the affiliate not having a on-call payment policy, the CO awarded the contract with a $1,000 per day which equated to $1,460,000 in total on-call costs.

We recommend that VHA document that on-call costs are in fact paid to the physicians performing the call. When on-call compensation is already built into the physician's salary agreement, then any additional compensation by VA to the affiliate for on-call service is merely embedded profit to the affiliate.

e) <u>Profit</u>. VA Directive 1663 states that profit should be aggressively discouraged when contracting with affiliated institutions because the medical schools receive other benefits by being affiliate of VA such as the training of residents at VA facilities. Since VA Directive 1663 was issued in 2006, we identified nine sole-source proposals that identified profit as a proposed cost.

In one instance, an affiliate included a five percent profit in their proposed costs. The affiliate told us that the $244,000 in profit was intended to cover any unexpected expenses incurred relating to contract performance. Our pre-award review questioned the line item cost because it did not represent an actual cost but was a contingency cost which is an unallowable cost per the provisions of FAR 31.205-7. The CO used these findings during negotiations which resulted in the affiliate revising its proposal to exclude profit. Also, based on our recommendations, the CO added an Economic Price Adjustment clause to the solicitation, which would allow price increases in the future if the affiliate provided sufficient justification.

It is more common for, affiliates to embed or disguise profit in one or more of the "cost elements" in the proposal. Profit is usually found in unsupported overhead

and on-call costs. If an affiliate is unable to demonstrate that the proposed administrative costs directly relate to providing services at VA, those costs essentially represent profit. Likewise, when an affiliate includes on-call costs in their proposal but is unable to provide any supporting evidence that the amount relates to costs incurred to provide the services, such as the funds are used to provide additional compensation to physicians for being on-call or otherwise expended to provide on-call services, this cost is actually profit to the affiliate.

We have observed that several COs are allowing profits in place of proposed costs that were questioned by the OIG. In the case of several healthcare service contracts awarded to an affiliate, VHA COs included profit as part of the contract costs. The awarded costs for profit ranged from 5 to 18 percent of the awarded contract costs. Upon questioning, the COs told us that the profit was granted to substitute for the indirect costs that were disallowed as a result of the OIG's pre-award review. Although the COs attempted to negotiate using the OIG recommendation of disallowing overhead, the university refused to remove these costs because they claimed that it would be lower than actual costs. The affiliate threatened to cease providing healthcare services at VA if they were not compensated for disallowed costs identified during the pre-award review. Although it is highly unlikely that the affiliate could cease providing services at VA because of the requirements of the ACGME approved medical training programs, VA COs capitulated and awarded contracts that include significant profits to the affiliate.

In a pre-award review for Ophthalmology and Ophthalmic imaging services, the OIG questioned $3,270,439 (47 percent) of the $6,891,029 in proposed costs. Although the CO did an excellent job and negotiated the contract's costs to $4,192,730, (a 39 percent savings), the awarded contract's Schedule of Supplies/Services and Price/Costs identified 18 percent profit, approximately $572,140, which is significantly lower than 36 percent profit requested by the affiliate. The CO stated that it was in the best interest of the Government to allow the 18 percent profit in order to award the contract.

2. Procedure Based Contracts Pricing Issues

a) Proposed Costs Exceeded Medicare Rates. Thirty of the 72 pre-award reviews that were conducted in FYs 2008 and 2009 were procedure based procurements. Seventeen (57 percent) of the 30 proposals included proposed costs that exceeded the full Medicare reimbursement rate. Thirteen of the 17 proposals contained prices that were simply a markup of Medicare while the remaining four proposals were at Medicare rates but inappropriately included the practice expense component. VA Directive 1663 states that pricing for services provided at VA on a per-procedure basis needs to be based only on the work and malpractice

components of Medicare Part B and not include the practice expense component which is the overhead component. The practice expense component, which can comprise 30 percent or more of the full reimbursement rate, is not to be included because it reimburses the provider for costs such as office space, supplies, support staff, etc., related to that procedure. VA incurs these costs directly to provide the services. Paying the full Medicare rate would result in VA paying twice for products and services. The Directive further states that any proposals that include pricing greater than the Medicare rate must have adequate documentation justifying the increased rate. For all reviews we found no valid justification for any markup in the Medicare rates or justification for inclusion of the practice expense component.

During our reviews we have asked affiliates and other vendors to provide justification for charging more than the full Medicare rate. Responses have varied but often cite prices paid by private insurers. However, in 11 years that the VA OIG has been conducting pre-award reviews, only one vendor (that was not an affiliate) agreed to provide data to support their assertion. In that particular pre-award review, we did rely on the private insurance prices to make recommendations regarding prices. In other reviews, we have been told that the proposed pricing (i.e., percent over the Medicare rate) was calculated to ensure payment covered the FTE costs associated with providing the services. This raises the question whether there was adequate justification for a procedure based contract to begin with. During a recent review, the affiliate justified the higher rate because the workload did not provide sufficient reimbursement for the time period VA required the providers to be present at the medical center. This problem demonstrates poor acquisition planning.

For example, an affiliate proposed 136 percent of the Medicare Part B, Physician Fee Schedule, rate for each required radiological procedure performed at a VAMC. Our pre-award review questioned the proposed costs because the affiliate did not provide adequate justification to support charging 136 percent of the full Medicare rate. The affiliate's methodology assumed the same cost escalation for all procedures without justifying the reason that any specific procedure should cost more than Medicare Part B rates and VA Directive 1663 allow.

After the OIG review, the affiliate submitted a revised proposal based on 130% of Medicare Part B rates for all procedures. The affiliate also maintained that they could not accept anything less than 130% because they would be losing money and stated that Medicare has not kept up with inflation. As part of contract negotiations, the CO analyzed Medicare Part B rates paid by other VAMC's for radiology services. The CO's analysis found that no radiology service contracts awarded by other VAMC's were less than 110 percent of Medicare and in most instances, were paid 115-135 percent above Medicare Part B rates. Despite our

recommendation to the contracting officer, the CO awarded the contract based on a price using the 130 percent of Medicare Part B rate. The analysis was flawed because the CO did not require the affiliate to validate its claim that they were in fact losing money. The CO simply compared the proposed prices to other VA radiology contracts; however, there was no validation of the price analysis that was done for any of those contracts. Although affiliates have argued that Medicare rates are not sufficient compensation, they fail to note that VA pays 100 percent of the fee whereas Medicare only pays 80 percent and they must incur additional administrative costs to collect the remaining 20 percent from the patient.

A concern directly raised by one affiliate and indirectly by other affiliates regarding procedure contracts at VA is that the quantity of procedures is not sufficient to cover their FTE cost. This is because VA requires a physician to be present for set hours which forces the affiliate to make an FTE commitment to VA; however, VA is only reimbursing the affiliate for the number of procedures performed. In one specific instance the affiliate stated they needed a markup of Medicare because they were concerned the necessary volume of procedures was insufficient and their dedicated FTE cost would not be covered. This argument was consistent with other affiliates that have attempted to justify their markup based on their FTE commitment as compared to the volume and revenue of the estimated procedures to be performed. When an affiliate is required by the SOW to have a certain number of physicians present at VA for a certain amount of time and there is not sufficient volume of procedures to cover their FTE costs, then the concerns of the affiliate is valid. Rather than attempt to estimate number of procedures and FTE to arrive at some markup of Medicare, we recommend that VA simply award an FTE based contract in these situations where affiliates express concern about the volume of procedures. In the alternative, VA should review their past workload to develop a more accurate requirement.

b) CPT Prices Not Included in Pricing Schedule.

Our reviews consistently identify solicitations that do not list CPT codes, estimates for the number of procedures expected to be performed, and/or a calculated price for each procedure. In fact, a procedure based contract that actually lists CPT codes in the pricing schedule with individual prices and estimated quantities is the exception to what we have found.

The typical price schedule in a per-procedure contract solicitation simply requires the affiliate to state their offered "prices" as a single percentage of Medicare. The price schedule typically is formatted as follows:

Orthopedic Procedures	Percent of Medicare	Estimated Quantity	Total Cost
CPT 50010-53850	110%	750	$422,044

This type of schedule does not quantify the individual CPT codes so that VA will have a reliable estimate of total cost and contract award. This type of schedule does not provide a definitive price schedule showing price for each CPT code so that the COTR or CO may certify invoices and verify that the correct price has been billed by the affiliate. This makes it difficult to award and administer the contract as the unit pricing is not clearly identified.

The importance of having a CPT listing was highlighted in a post-award review we conducted in 2008 of a procedure based contract for urological services. The schedule of services simply stated that the awarded prices were 100 percent of Medicare reimbursement rates geographically adjusted for the region. There was no pricelist in the contract showing the CPT codes and the awarded price for each. During the post-award review we determined that the affiliate had not computed the CPT rates correctly and submitted incorrect rates and invoices to VA. We determined that the affiliate failed to geographically adjust the rates as stipulated in the contract. When we discussed our findings with VHA officials, they stated that they had no way of knowing whether or not they were billed the correct rates since there was no price list to compare the invoiced rates to and they had no expertise in calculating Medicare reimbursement rates. They stated they relied on the affiliate to calculate the correct rates.

When we discussed our findings with officials at the affiliate, they stated that they were not experts in calculating Medicare reimbursement rates either. They have billing and coding experts who know how to accurately bill Medicare in terms of using the correct CPT codes, but when they send the invoice to Centers for Medicare and Medicaid Services (CMS) the invoice merely lists their usual and customary charges. CMS then calculates the correct Medicare reimbursement rates and adjusts the invoice accordingly. Because VA did not include a CPT listing in the pricing schedule with unit prices there was no price list for VA to use to verify that the rates were accurate. As a result, VA overpaid a total of $62,000 for urological services.

c) Mixed FTE and Procedure Based Contracts. Seven pre-award reviews were of proposals that included costs that were based on a combination of FTE and per-procedure. Our reviews found that none of the proposals included provisions to ensure that VA did not overpay for services. Typically the procedure component was for surgical procedures done in an operating room setting and the FTE portion was for staffing the weekly or daily clinic. Normally, Medicare sets a global period for surgical procedures that may be as high as 90 days. This means that any normal post-operative care for that procedure that occurs in the stated time frame is performed at no additional cost—all post-operative care costs are factored in the cost of the procedure. If a contractor is paid the full global rate for

a procedure and then the veteran patient receives their post-operative care in a clinic setting that is staffed by a contracted physician, then VA is essentially paying twice for the post-operative care. We determined that none of the six proposals had any provisions to ensure VA did not pay twice for any costs related to pre-operative or post-operative care. Based on our review and discussions with procurement officials, we believe the main reason is that they were simply unaware of the potential that VA could overpay when FTE and procedure contracts are combined because they lack understanding that the Medicare rate is inclusive of normal post-operative care and where that post-operative care was taking place.

To address these issues we recommend that VHA provide specific training on procedure based contract issues and how Medicare reimbursement rates are calculated and what they include. We recommend that VHA require all procedure based contracts to include a pricing schedule identifying the CPT codes and estimated quantity for each CPT code. To address administrative issues regarding payment, we recommend that VHA conduct an evaluation to determine the feasibility of using a third party administrator to process billings for procedure contracts performed at the affiliate in a similar fashion as the Medicare administrators.

C. Other Issues

We have identified two additional important issues regarding the awarded pricing for sole-source contracts with affiliates:

1. Conflict of Interest
2. Personal Services Contracts

These two issues were also identified in our 2005 report. Based on our pre-award reviews since the adoption of Directive 1663, conflicts of interest issues continue to be cited as a problem area. Also, we still recommend that VA seek legislative authority to award personal services contracts.

1. Conflict of Interest

As cited in VA Directive 1663, an employee is prohibited by law from participating in the procurement for healthcare resources if the employee has certain relationships as listed in VHA Handbook 1660.3, with non-VA parties involved in the procurement. From the sample of 106 reports (FYs 2008 to 2010), 14 reports identified an individual(s) with a potential conflict of interest, which represents a decrease from the 2005 report. In most instances, the conflicts of interest were the result of a VA official named in the healthcare resource solicitation as participating in the award or

administration of the contract who also had a financial interest with the contractor, usually through a faculty appointment and/or as a part-time employee of the affiliate. Noted examples of conflict of interest findings were as follows.

- A VA Chief of Radiology signed off on procedures performed under the proposed contract although he worked part-time for the affiliate.
- A part-time physician at VA was a dual employee who also worked part-time at for the affiliate. He was one of the proposed contract physicians providing healthcare services at the VA Medical Center. In addition, as a VA employee, he planned to participate in the negotiations. As stated in Directive 1663, the general rule is that part-time VA physicians should not provide the same services under contract for which they receive VA pay. However, under special circumstances, a waiver may be approved by the Medical Center Director in conjunction with the regional office of general counsel.

These two examples of conflicts of interest violate 18 U.S.C §208 and 5 C.F.R. §2635.402, which prohibits an employee from participating personally and substantially in an official capacity in any particular matter in which their interests are imputed to them under this statue has a financial interest.

Procedure based contracts are of special concern when the service is being rendered at VA and there are VA employees involved who have a faculty appointment or other relationship with the affiliate. VA's Office of General Counsel has issued an opinion that states there is a conflict of interest when there is a procedure based contract at VA and dual appointed employees are involved. This conflict exists even when the VA employee is working as VA employee because his or her actions have a direct and predictable financial impact on the affiliate. Essentially, the VA physician is in a position to do fewer procedures thus increasing the workload for the affiliate to perform under the contract which increases the revenue under the contract.

2. Prohibited Personal Services Contracts

FAR 37.104 prohibit agencies from entering into personal services contracts unless specifically authorized by statute. 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." Neither § 8153 nor § 7409 specifically authorizes VA to enter into personal services contracts. VHA and OGC have determined that contracts awarded pursuant to § 8153 or § 7409 cannot be for personal services.

In our 2005 report, we concluded that the sole-source contracts for physician services awarded under § 8153 were for all practical purposes personal services

contracts (the full text regarding this issue is included in Exhibit B). This was determined by applying the six guidelines set forth in FAR 37.104:

- 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 one 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. Our 2005 report determined that for most of the contracts we reviewed, the response would be "yes" to most questions. Our report also discussed that the duties described in the SOW typically can be defined as inherent governmental functions which gives credence that these contracts are in fact personal services contracts. Our report also raised concerns regarding liability issues and the ability of the Government to effectively defend itself under the Federal Tort Claims Act.

The Under Secretary for Health concurred with our recommendations to seek legislation to amend Title 38 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility. The Under Secretary for Health stated that VHA will, in collaboration with the Department, develop the request.

While VA did submit a legislative proposal prepared by the OIG to OMB, VHA also objected to the proposal stating that moving from non-personal services contracts to personal services contracts would not be cost effective. However, VHA officials did not adequately support their claim. We believe that sole-source contracts with affiliates have the potential to decrease because malpractice costs would be removed from the contract. More importantly, it would allow VA to better supervise and manage the care provided to veterans in VA hospitals.

CONCLUSIONS

VHA has not invested the resources necessary to implement the policy requirements contained in VA Directive 1663. VHA has not provided training to the contracting and non-contracting staff to ensure responsible officials understand the requirements and policy of VA regarding sole-source contracts with affiliated institutions. We have determined there has been no consistent nation-wide implementation and application of VA policy regarding sole-source contracting with affiliates. As a result, some affiliates have been permitted to charge VA unsupported overhead while others have not. Some affiliates have been permitted to include unsupported on-call costs while other affiliates have not. Some affiliates have been permitted to charge prices at higher than Medicare rates for procedure based contracts while others have not. The lack of consistency for these and the other issues identified in this report creates confusion and lacks a unified approach to sole-source contracting with affiliates nation-wide which was the one of the main objectives for Directive 1663. We recommend that VHA agree with our findings and concur with our recommendations to take immediate and concrete steps to uniformly implement and strengthen VA policy contained in Directive 1663.

RECOMMENDATIONS

We recommend that the Undersecretary for Health:

1. Evaluate and determine the resources needed by MSO to uniformly implement and monitor compliance with the requirements set forth in Directive 1663 on a nation-wide basis.
2. Develop and implement a central tracking system that captures and reports all healthcare contracting and spending with affiliates for healthcare services including interim agreements.
3. Develop and provide comprehensive standardized training for VHA contracting staff regarding sole source contracting with affiliates and the requirements of Directive 1663.
4. Develop and provide comprehensive standardized training on the requirements of VA Directive 1663 to non-procurement staff who have responsibilities relating to sole source contracting with affiliates.
5. Ensure VHA contracting staff adhere to all policy requirements contained in VA Directive 1663, including the following:
    a. Each procurement should be adequately planned.[*]
    b. A backup plan for an alternate source for services should be established.
    c. Contracts should be competed except where VA has established a need for services from a faculty member of the affiliate.
    d. Salary surveys should not be used to determine fair and reasonable pricing.
    e. The key personnel clause is contained in each FTE contract and properly identifies each physician.[*]
    f. Limiting overhead to costs directly associated with administration of the VA contract.[*]
    g. On-call costs are only permitted when physicians are actually compensated for being on-call.[*]
    h. Procedure based contracts should not be awarded at rates higher than Medicare unless clearly justified and should exclude the practice expense component when performed at VA.[*]
6. Develop a standard that accurately defines the expected hours and workload from one FTE for each specialty that can be applied by the contracting staff to determine the number of FTE and hours to be procured under the contract.[*]
7. Develop clear and well defined national standard SOWs for each specialty that can be tailored as needed to address specific procurement requirements if needed.

[*] A similar recommendation was made in our 2005 report.

8. Develop and require the use of a standard pricing schedule for procedure based contracts that require the listing of all CPT codes with estimated quantities and proposed prices for each code.
9. Conduct an evaluation to determine the feasibility of using an administrator or intermediary to process billings for procedure based contracts performed at the affiliate similar to those used by Medicare administrators.
10. Develop a more robust process to ensure compliance with conflict of interest laws and regulations and their applicability to all Title 38 employees who have a relationship with affiliates.[*]
11. 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.[*]

[*] A similar recommendation was made in our 2005 report.

ACRONYMS

AAMC	Association of American Medical Colleges
ACGME	Accreditation Council for Graduate Education
CBOC	Community Based Outpatient Clinic
CMS	Centers for Medicare and Medicaid Services
CO	Contracting Officer
Committee	Medical Sharing Office Committee
COTR	Contracting Officer's Technical Representative
CPT	Current Procedure Terminology
eCMS	Electronic Contract Management System
FAR	Federal Acquisition Regulations
FTE	Full Time Equivalent
FY	Fiscal Year
MSO	Medical Sharing Office
OAA	Office of Academic Affiliations
OCR	Office of Contract Review
OIG	Office of Inspector General
PNM	Price Negotiation Memorandum
SDVOSB	Service-Disabled Veteran-Owned Small Business
SOW	Statement of Work
U.S.C.	United States Code
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 1: VA New England Healthcare System	
Boston University School of Medicine	0
Tufts University School of Medicine	0
Harvard Medical School	0
Dartmouth Medical School	0
University of Massachusetts Medical School of Worcester	0
Boston University School of Medicine	0
Brown University Program in Medicine	0
University of Massachusetts Medical School	0
University of Connecticut School of Medicine	0
Yale University School of Medicine	1
	1
VISN 2: VA Healthcare Network Upstate New York	
Albany Medical College of Union University	0
State University Of New York At Buffalo School Of Medicine	0
University of Rochester School of Medicine and Dentistry	0
State University Of New York Upstate Medical University	0
	0

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 3: VA NY/NJ Veterans Healthcare Network	
Mount Sinai School of Medicine of City University of New York	0
State University of New York Health Science Center at Brooklyn College of Medicine	1
UMDNJ-New Jersey Medical School	1
UMDNJ-Robert Wood Johnson Medical School	0
New York Medical College	0
New York University School of Medicine	1
State University Of New York at Stony Brook, School of Medicine	1
	4
VISN 4: VA Stars and Stripes Healthcare Network	
West Virginia University School of Medicine	1
Temple University School Of Medicine	0
Pennsylvania State University College of Medicine	0
Allegheny University of the Health Sciences/MCP-Hahnemann School Of Medicine	0
University of Pennsylvania School of Medicine	0
University of Pittsburgh School of Medicine	6
Allegheny University of the Health Sciences/MCP-Hahnemann School Of Medicine	0
Jefferson Medical College of Thomas Jefferson University	0
University of Maryland School of Medicine	0
	7
VISN 5: VA Capitol Healthcare Network	
University of Maryland School of Medicine	2
George Washington University School of Medicine	2
West Virginia University School of Medicine	1
Howard University College of Medicine	0
Georgetown University School of Medicine	0
	5

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 6: VA Mid-Atlantic Healthcare Network	
Duke University School of Medicine	3
University of North Carolina at Chapel Hill School of Medicine	0
Eastern Virginia Medical School of the Medical College of Hampton Roads	0
Virginia Commonwealth University, Medical College of Virginia	4
University of Virginia School of Medicine	0
Wake Forest University School Of Medicine	0
	7
VISN 7: The Southeast Network	
Emory University School of Medicine	1
Medical College of Georgia	2
University Of Alabama School Of Medicine	8
Medical University of South Carolina School of Medicine	2
Mercer University School of Medicine	0
University of Alabama School Of Medicine	0
Morehouse School of Medicine	0
	13
VISN 8: VA Sunshine Healthcare Network	
University of South Florida College of Medicine	1
University of Florida College of Medicine	3
University of Miami School of Medicine	3
University of Puerto Rico School of Medicine	0
University of South Florida College of Medicine	0
	7

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 9: VA Mid-South Healthcare Network	
Marshall University School of Medicine	0
University of Kentucky College of Medicine	1
University of Louisville School of Medicine	3
University of Tennessee College of Medicine	2
East Tennessee State University, James H Quillen College of Medicine	0
Meharry Medical College School of Medicine	2
Vanderbilt University School of Medicine	1
	9
VISN 10: VA Healthcare System of Ohio	
Ohio University, College of Osteopathic Medicine	0
A.T. Still University, School of Osteopathic Medicine	0
University of Cincinnati College of Medicine	1
Case Western Reserve University School of Medicine	0
Ohio State University College of Medicine	1
Wright State University School of Medicine	1
	3
VISN 11: Veterans in Partnership	
University of Michigan Medical School	4
Michigan State University Kalamazoo Center for Medical Studies	0
University of Illinois College of Medicine	0
Wayne State University School of Medicine	1
Indiana University School of Medicine	9
	14

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 12: VA Great Lakes Healthcare System	
Loyola University of Chicago, Stritch School of Medicine	1
Medical College of Wisconsin	2
Northwestern University Medical School	0
University of Wisconsin Medical School	1
Rosalind Franklin University of Medicine & Science	0
University of Illinois College of Medicine	1
	5
VISN 15: VA Heartland Network	
University of Missouri, Columbia School of Medicine	2
University of Kansas School of Medicine	0
Saint Louis University School of Medicine	0
Southern Illinois University School of Medicine	0
Saint Louis University School of Medicine	0
Saint Louis School of Pharmacy	1
Washington University School of Medicine	0
	3
VISN 16: South Central VA Healthcare Network	
Tulane University School Of Medicine	0
University of South Alabama College of Medicine	0
Baylor College of Medicine	0
University of Mississippi School of Medicine	1
University of Arkansas College of Medicine	3
University of Oklahoma College of Medicine	0
Louisiana State University	2
University of Oklahoma College of Medicine	4
	10

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 17: VA Heart of Texas Healthcare Network	
University of Texas Southwestern Medical School at Dallas	11
University of Texas Medical School at San Antonio	1
Texas A & M University College of Medicine	0
	12
VISN 18: VA Southwest Healthcare Network	
University of New Mexico School of Medicine	2
Texas Tech University Health Science Center School of Medicine	0
University of Arizona College of Medicine	1
	3
VISN 19: Rocky Mountain Network	
University of Colorado School of Medicine	4
University of Utah School of Medicine	2
	6
VISN 20: Northwest Network	
University of Washington School of Medicine	0
Oregon Health Sciences University School of Medicine	1
	1
VISN 21: Sierra Pacific Network	
University of Hawaii John A Burns School of Medicine	0
University of California, Davis School of Medicine	0
Stanford University School Of Medicine	2
University of Nevada School of Medicine	3
University of California, San Francisco School of Medicine	0
	5

EXHIBIT A

OIG Healthcare Resource Pre-award Reports Issued by VISN and Academic Affiliates

From October 1, 2006 - September 30, 2010

VISN's Academic Affiliates	OIG Reports Issued
VISN 22: Desert Pacific Healthcare Network	
University of Nevada School of Medicine	3
Loma Linda University School of Medicine	0
University of California, California College of Medicine	0
University of California, San Diego School of Medicine	0
University of Southern California School of Medicine	0
University of California, Los Angeles School of Medicine	0
	3
VISN 23: VA Midwest Healthcare Network	
University Of North Dakota School Of Medicine	0
University of Minnesota Medical School	2
University of South Dakota School of Medicine	0
University of Iowa College of Medicine	3
Creighton University School of Medicine	1
University of Nebraska College of Medicine	3
	9
All Healthcare Reports issued by OIG	127
All Other Reviews - Non-Affiliate, CBOCs, and competitive bids	4
Total Healthcare Resource Reports Issued by OIG	131

EXHIBIT B

Excerpt from Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, February 16, 2005, Regarding Prohibited Personal Services Contracts

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."[1] 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.[2]

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 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)

[1] 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.)

[2] 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."

Excerpt from Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, February 16, 2005, Regarding Prohibited Personal Services Contracts

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 (SOW) 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.[3] 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."

[3] 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."

Excerpt from Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, February 16, 2005, Regarding Prohibited Personal Services Contracts

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. [4]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

[4] 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."

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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 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:

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> "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

Excerpt from Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, February 16, 2005, Regarding Prohibited Personal Services Contracts

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.[5]

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.

[5] 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.

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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- 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."

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- "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:[6]

- Direction and assistance support of CRNAs, anesthesia assistants, staff anesthesiologists and other anesthesia service personnel.[7]

- Educational training and supervision of residents, medical students and CRNAs.
- 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

[6] 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.
[7] These individuals are VA, not contractor employees.

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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.[8]

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 SOWs in both contracts[9] 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.

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 §

[8] OFPP Policy Letter 92-1, Appendix A, paragraph 7.

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

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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.[10] 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.

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

[10] The medical malpractice component of the proposals ranged from 0 percent to 11.07 percent.

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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.

APPENDIX A

MANAGEMENT COMMENTS

Department of Veterans Affairs

Memorandum

Date: July 11, 2011

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Sole-Source Contracts with Affiliated Institutions (VAIQ 7121924)

To: Director, Healthcare Resources, Office of Contract Review, Office of Inspector General (55)

1. I have reviewed the draft report and concur that the Office of Inspector General (OIG) has identified current concerns as well as past issues with compliance required by Department of Veterans Affairs Directive 1663, Health Care Resources Contracting – Buying Title 38 U.S.C. 8153.

2. It is important to note that the Veterans Health Administration has within the last year, after also identifying significant concerns about healthcare contracting and spending with affiliates for healthcare services, taken aggressive action to address these issues. Steps include:
   - Bolstering leadership and employment in the Medical Sharing Office;
   - Instituting new processes and procedures for tracking this healthcare contracting and spending;
   - Improving training;
   - Beginning to develop updated standard operating procedures for acquisition planning, establishment of backup plans for alternate sources for services, additional scrutiny of sole source justifications, and implementation of new checklist processes.

3. The OIG report includes suggestions that need attention. It is important to note that several issues may require serious discussions with the OIG review team to develop practices and processes that ensure solid procurements using sole source contracts. VHA is dedicated to work with OIG to develop and implement practical and sound solutions that will work effectively.

Page 2.

OIG Draft Report, Review of Sole-Source Contracts with Affiliated Institutions (VAIQ 7121924)

4. The report[1] suggests that there has been pressure from the Association of American Medical Colleges (AAMC) and some of its member universities to influence VA's sole source contracting policy. My reaction is that whereas it would be inappropriate to allow AAMC to participate in the development and writing of VA policy it is both reasonable and necessary to seek input from key stakeholders such as the AAMC during policy development so that stakeholder interests are identified and considered in advance and the potential impact of policy on VA's statutory academic mission is taken into account. VHA often consults with a variety of stakeholders, including our academic partners, prior to finalizing policies and procedures to maximize policy feasibility. This does not mean that a stakeholder's interest should or would be put above VHA or Veterans' needs.

5. Thank you for the opportunity to review the draft report. Attached is the Veterans Health Administration's corrective action plan for the report's recommendations. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Attachment

[1] Pages 3 and 4, "Since early 2007…of the affiliates."

APPENDIX A

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Review of Sole-Source Contracts with Affiliated Institutions (VAIQ 7121924)

Date of Draft Report: April 25, 2011

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommend that the Undersecretary for Health evaluate and determine the resources needed by MSO to uniformly implement and monitor compliance with the requirements set forth in Directive 1663 on a nation-wide basis.

VHA Comments

Concur

The Veterans Health Administration (VHA) recognizes the need for additional resources and three additional staff reported June 2011. The individuals are being hired as GS-14, Lead Negotiators, for each Service Area Organization (SAO).

Completed

Also, VHA leadership has approved three additional positions in the Medical Sharing Office (MSO) to support the oversight and compliance of healthcare contracting required by Veterans Affairs (VA) Directive 1663, Health Care Resources Contracting – Buying Title 38 U.S.C. 8153. This will result in a total of 10 full-time equivalents (FTE) to support the VHA Medical Sharing/Affiliate Program.

Completed

Recommendation 2. We recommend that the Undersecretary for Health develop and implement a central tracking system that captures and reports all healthcare contracting and spending with affiliates for healthcare services including interim agreements.

VHA Comments

Concur

A MSO Review/Approval Tracking System that allows the MSO to track all healthcare procurements processed in accordance with VA Directive 1663, to include selling, interim contract requests, and transplant contracts, has been completed.

Completed

In addition, MSO has assigned a management analyst with sole responsibility to generate reports using the data systems such as Electronic Contract Management System (eCMS), Federal Procurement Data System (FPDS), Micro Strategy, Zycus. The analyst will extract data, monitor and validate that procurements are being processed in accordance with VA Directive 1663.

Completed

Also, the MSO Office of Inspector General (OIG) Tracking Log has been created to allow VHA through the MSO to monitor and track procurements requiring OIG pre-award review in accordance with VA Directive 1663. This system also allows MSO to identify lag time from the date a proposal is received from an affiliate to the date it is submitted to OIG for pre-award review. This information will be used to implement MSO intervention plans when a VA Medical Center (VAMC) or an affiliate is not responsive to procurement processes. Both systems were launched May 9, 2011, and are fully operational.

Completed

Recommendation 3. We recommend that the Undersecretary for Health develop and provide comprehensive standardized training for VHA contracting staff regarding sole source contracting with affiliates and the requirements of Directive 1663.

VHA Comments

Concur

VHA through the MSO is assisting VA Acquisition Academy (VAAA) in developing course work for the first official Healthcare Contracting Course. In the interim, two VHA Contracting Officers (CO) have been designated as instructors to address current educational needs. Pilot classes, two classroom and two on-line sessions, are being conducted in summer 2011.

In process December 31, 2011

MSO has supported the SAOs in augmenting healthcare training at the SAO Healthcare Symposiums. A symposium was held in January and March of 2011 to support the healthcare teams for SAO East and Central.

Completed

The MSO Re-Design Plan provides for conducting monthly training sessions via Live Meeting and teleconference to provide real-time training on processes, trends, and any deficient areas identified by the MSO Director and reported to the Chief Procurement and

Logistics Officer. This monthly training also provides an opportunity to conduct cross functional training with other support partners such as Patient Care Services (PCS), OIG, VA Office of General Counsel (OGC), Regional Counsel, etc. First sessions are scheduled for summer 2011. Training will be documented and monitored by the SAO Training Officers and the MSO.

Ongoing December 31, 2011

Recommendation 4. We recommend that the Undersecretary for Health develop and provide comprehensive standardized training on the requirements of VA Directive 1663 to non-procurement staff who have responsibilities relating to sole source contracting with affiliates.

VHA Comments

Concur

VHA will conduct a needs assessment to identify the appropriate non-procurement staff requiring training or informational briefings. In addition, VHA will determine training delivery methods and implement standardized guidance supported by live training or face-to-face training efforts across VHA.

In process. Action plan with timelines to be completed NLT December 31, 2011.

Recommendation 5. We recommend that the Undersecretary for Health ensure VHA contracting staff adhere to all policy requirements contained in VA Directive 1663, including the following:

a. Each procurement should be adequately planned.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. VHA, through the VHA Acquisition Quality Director, is currently developing a VHA Standard Operating Procedure (SOP) for acquisition planning. An acquisition planning guide will define roles and responsibilities of VAMC program officials and contracting officials to ensure a procurement integrity protocol is established. The MSO Director is developing supplemental guidance to address unique issues related to sole source procurements with an affiliate. This will be included in the SOP and the acquisition planning guide. Also, field program training conducted by the SAO and Network Contracting Activity (NCA) Contracting Training Officers will follow.

In process December 31, 2011

b. A backup plan for an alternate source for services should be established.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. An SOP is being developed to identify the formats and templates. These templates will required a detailed explanation of the alternate source plan as required by VA Directive 1663.

In process December 31, 2011

c. Contracts should be competed except where VA has established a need for services from a faculty member of the affiliate.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. The current MSO review process includes detailed scrutiny of sole source justifications to ensure compliance with VA Directive 1663. The justifications require VAMC leadership to identify patient care, educational, and research program impacts as well as general value to VA (e.g., the collateral value of VA's longstanding partnership with the academic community) to support sole source procurement recommendations.

In process December 31, 2011

d. Salary surveys should not be used to determine fair and reasonable pricing.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. VHA would like to note that this needs additional attention. In order to address this and other related issues, a workgroup has been convened with representatives from the VHA Office Academic Affiliations (OAA), the MSO, PCS, SAO Price Analysts, and VHA Field COs to focus on how to achieve consistent costing and contracting practices and address other topics such as educational indirect costs and payment for on-call coverage. This group will analyze the strategies and costing issues used by the MSO negotiation teams and recommend methods and tools required to determine fair and reasonable price as it applies to the Federal Acquisition Regulations and Standard Cost policies. Then, policy changes would be considered and implemented as needed. As a measure of improvement and compliance, the documentation requirements have been defined to support fair and reasonable price determination in the Price Negotiation Objective Memorandum which is

incorporated as part of the official contract file and support of the Price Negotiation memorandum.

VHA will consult with OIG to ensure that concerns outlined in this report are addressed.

In process Workgroup Recommendation issued to USH NLT December 31, 2011

e. The key personnel clause is contained in each FTE contract and properly identifies each physician.

<u>VHA Comments</u>

Concur

VHA will follow VA Directive 1663 requirements. A quality control checkpoint will be added to the VHA Healthcare Contract Review Checklist to ensure incorporation of this clause on all contracts. In addition, this topic has been included in the VAAA Healthcare Contracting Course.

In process December 31, 2011

f. Limiting overhead to costs directly associated with administration of the VA contract.

<u>VHA Comments</u>

Concur

VHA will follow VA Directive 1663 requirements. While the current directive limits overhead to costs directly associated with administration of the VA contract and OIG's review indicates concerns about whether this is followed at all times, VHA would like to note that this needs additional attention. In order to address this, the workgroup established to focus on how to achieve consistent costing and contracting practices will also analyze overhead costs and the methods and tools required to determine fair and reasonable price as it applies to the Federal Acquisition Regulations, Standard Cost policies, and VHA policy including a revision to VA Directive 1663 which is currently in process.

VHA will consult with OIG to ensure that concerns outlined in this report are addressed.

In process Workgroup recommendations issued to USH NLT December 31, 2011

g. On-call costs are only permitted when physicians are actually compensated for being on-call.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. While the current directive only permits on-call costs when physicians are actually compensated for being on-call, and OIG's review indicates concerns about whether this is followed at all times, VHA would like to note that this needs additional attention. In order to address this, the workgroup established to focus on how to achieve consistent costing and contracting practices will also analyze the on-call issues and develop recommendations about identifying the limitations as they apply to on-call that will be considered in a revision of VA Directive 1663 which is currently in process.

VHA will consult with OIG to ensure that concerns outlined in this report are addressed.

In process Workgroup recommendations issued to USH NLT December 31, 2011

h. Procedure based contracts should not be awarded at rates higher than Medicare unless clearly justified and should exclude the practice expense component when performed at VA.

VHA Comments

Concur

VHA will follow VA Directive 1663 requirements. As a measure of improvement, the new negotiation process has incorporated a standardized Price Negotiation Objective Memorandum that allows for adequate documentation regarding final decision to award above the Medicare rates if the negotiation circumstances require such a determination. In addition, this subject has been included in the VAAA Healthcare Contracting Course and will be a focus topic for the MSO Monthly Augmentation Training to be scheduled first quarter of Fiscal Year 2012.

MSO is also coordinating with the VAAA to discuss developing a new curriculum about healthcare cost and pricing.

In process December 31, 2011

Recommendation 6. We recommend that the Undersecretary for Health develop a standard that accurately defines the expected hours and workload from one FTE for each specialty that can be applied by the contracting staff to determine the number of FTE and hours to be procured under the contract

VHA Comments

Concur

To address this issue, VHA's MSO will partner with appropriate stakeholders to identify how best to establish parameters that contracting staff can use to determine the number of FTE and hours to be procured under a contract. It is important to recognize that achieving this goal will be complicated given the many specialties and unique situations involve with providing health care. This is also to be considered in a revision of VA Directive 1663 which is currently in process.

VHA will consult with OIG to ensure that concerns outlined in this report are addressed.

In process Recommendations are to be issued to USH NLT December 31, 2011

Recommendation 7. We recommend that the Undersecretary for Health develop clear and well defined national standard SOWs for each specialty that can be tailored as needed to address specific procurement requirements if needed.

VHA Comments

Concur

In November 2010 the VHA Medical Sharing Committee started to identify specialty areas for standardizing Performance Work Statements (PWS) and Quality Assurance Surveillance Plans (QASP). The committee provides guidance on all proposed contract sharing agreements that are competed or sole sourced with affiliates and other healthcare providers. Guidance provided includes instruction on compliance with statutory and VA policy requirements, clinical soundness, patient safety, quality and cost effectiveness of sharing agreements.

In April 2011, the Community Based Outpatient Clinic (CBOC) and Radiation Oncology (Off-site/On-site) templates were completed. They are posted on the MSO Share Point for use by VHA field contracting officials and programs. The next Medical Sharing Committee reviews will be Interventional Radiology, Neurology, and Orthopedic. This will be an on-going effort.

Ongoing

Recommendation 8. We recommend that the Undersecretary for Health develop and require the use of a standard pricing schedule for procedure based contracts that require the listing of all CPT codes with estimated quantities and proposed prices for each code.

VHA Comments

Concur

VHA agrees that it is important to evaluate how best to use CPT codes in future contracts. To accomplish this, MSO will partner with appropriate stakeholders to develop action plans, solutions, and implementation plans. Because some services are not routinely billed utilizing CPT codes, these services will need to be identified and guidance established for the field. In other cases, using CPT codes may not be the most advantageous way to contract for specific services. Other alternatives will need to be developed in these cases. During this evaluation process, VHA will consult with OIG to ensure that concerns outlined in this report are addressed.

In process Recommendations are to be issued to USH NLT December 31, 2011.

Recommendation 9. We recommend that the Undersecretary for Health conduct an evaluation to determine the feasibility of using an administrator or intermediary to process billings for procedure based contracts performed at the affiliate similar to those used by Medicare administrators.

VHA Comments

Concur

Statutory requirements and other issues about using an administrator or intermediary to process billings for procedure based contracts as used by Medicare administrators may affect how VHA can use these processes. The MSO Director and appropriate stakeholders will examine this issue and provide recommendations to the USH.

In process Recommendations are to be issued to USH NLT December 31, 2011

Recommendation 10. We recommend that the Undersecretary for Health develop a more robust process to ensure compliance with conflict of interest laws and regulations and their applicability to all employees, particularly Title 38 employees, who have a financial relationship with the contractor.

VHA Comments

Concur

VHA's MSO has implemented a Negotiation Kick-Off Checklist which requires each CO to conduct a Conflict of Interest (COI) assessment. If a member of the negotiation team

is found to have a COI, the MSO requests assistance from VAMCs within that specific VISN to support the procurement effort. If the VISN does not have the availability of a physician within that specialty, then assistance is requested from another VISN and VHA Central Office. This process is being included in the VHA Healthcare SOP referenced previously.

A team will be formulated with representatives from OAA, VHA senior leadership, VHA VISN Chief Medical Officers (CMO), OGC, and MSO to discuss a revision of VHA Handbook 1660.3, Conflict of Interest Aspects of Contracting Scare Medical Specialist Services, Enhanced Use Leases, Healthcare Resource Sharing, Fee Basis and Intergovernmental Personnel Act Agreements (IPA), to clarify the COI verification process for any person involved in the procurement process.

In process Action plan recommendations to USH NLT December 31, 2011

Recommendation 11. We recommend that the Undersecretary for Health 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.

VHA Comments

Concur

Due to the significant impact on several program areas, representatives from OGC, OAA, VHA senior leadership, and MSO will discuss the potential risks for awarding these types of contracts and formulate recommendation to the USH.

In process Recommendations are to be issued to the USH NLT December 31, 2011

Veterans Health Administration
July 2011

APPENDIX B

OIG CONTACT AND STAFF ACKNOWLEDGMENTS

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APPENDIX C

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