

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS  
BEFORE  
THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
HEARING ON  
"REVIEW OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS  
CONTRACT HEALTH CARE: PROJECT HERO"  
ON  
FEBRUARY 3, 2010**

**INTRODUCTION**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our findings related to how the Veterans Health Administration (VHA) purchases health care services for veterans from non-VA providers. I am accompanied by Gary Abe, Director, Seattle Office for Audits and Evaluations, Office of Inspector General (OIG). As health care costs continue to increase in VA and elsewhere, ensuring that VA has strong controls over purchased care activities is a critical aspect of providing the care veterans need. To address this concern, over the past 2 years, we have issued two reports—*Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements* and *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*. In addition, we are currently reviewing the Inpatient Fee Care Program and FSS contracts for professional and allied health services; we plan to issue audit reports on these issues later in FY 2010. To date, our audits of purchased care have identified significant weaknesses and inefficiencies. Specifically, we have found that VHA has not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly billed.

**BACKGROUND**

When we initiated our audits in fiscal year (FY) 2008, VHA's medical care budget totaled approximately \$39 billion. In FY 2009, the medical care budget increased to about \$44 billion. We estimate that of this amount, VHA spent about \$5.3 billion (12 percent) to purchase health care services from non-VA entities such as other government agencies; affiliated universities; community hospitals; nursing homes; and individual providers. VHA uses various mechanisms to purchase health care services, including sharing agreements with affiliated universities and the Department of Defense, Federal Supply Schedule (FSS) contracts, the Non-VA Fee Care Program, Project HERO, and the Foreign Medical Program. According to VHA managers, the authority to purchase services from non-VA sources helps to improve veterans' access to needed health care services, in particular specialty care that may not be available at VA medical

centers (VAMCs) or that VAMCs have a difficult time recruiting and retaining specialists to provide.

#### Audit of Noncompetitive Clinical Sharing Agreements

Title 38 of the United States Code (USC), Section 8153, authorizes VA to enter into noncompetitive sharing agreements with affiliated institutions and entities associated with these institutions. In practice, many sharing agreements are ones in which VA buys specialized clinical services, such as anesthesiologists or cardiac surgeons, from affiliated medical schools, university hospitals, clinical departments, and associated medical practice groups. These medical specialists provide services onsite in VAMC operating rooms, clinics, and inpatient medical wards. When we initiated the audit in FY 2008, VHA reported having about 670 noncompetitive clinical sharing agreements valued at \$575 million.

Performance monitoring controls over noncompetitive clinical sharing agreements were not effective; as a result, VHA lacked reasonable assurance it received the services it paid for. Our review of 58 high cost surgical and anesthesiology sharing agreements at 8 randomly selected VAMCs found that controls over contract performance monitoring for services provided onsite at the VAMCs under all 58 agreements needed strengthening.

- For 34 full-time equivalent employee (FTE) based agreements, contracting officers' technical representatives (COTRs) did not monitor the actual amount of time contractors worked or whether the hours worked met the FTE levels required by the agreements. For example, one VAMC paid for 2.0 FTE vascular surgeons, but our review determined that the time provided by contract vascular surgeons equated to less than 1.2 FTE. The COTR acknowledged that while she reviewed the surgeons' workload, she did not monitor their time. As a result, the VAMC overpaid \$333,030 for time the vascular surgeons were not at the VAMC.
- For 24 procedure-based agreements, COTRs did not always ensure that all of the services were actually received or needed and that contractors correctly calculated Medicare-based charges. For example, at one VAMC, a contractor overcharged \$1,022 for 31 procedures because it billed rates that were higher than the Medicare rates applicable to the geographical area. The COTR did not review the charges or verify the accuracy of the rates prior to certifying payments. If left unmonitored, even routine procedure billings with low value financial errors can build over time into significant overpayments.

Because of these weaknesses in performance monitoring, VAMCs overpaid contractors on 30 (52 percent) of the 58 agreements. Strengthening controls over performance monitoring would save VHA about \$9.5 million annually or \$47.4 million over 5 years.

Specifically, we identified three areas that required strengthening:

- **Specify Performance Requirements.** The sharing agreements did not specifically and accurately state performance requirements for the contractors. Clear performance requirements tell the COTRs what services will be provided, who will provide the services, and the rates to be charged.
- **Improve Oversight of COTRs.** Contracting officers and VHA officials did not adequately oversee COTR activities. Contracting officers did not provide the COTRs clear guidance about their monitoring responsibilities, nor did they implement procedures to routinely review the COTRs' activities to ensure they were effective.
- **Provide Specialized Training to COTRs.** COTRs did not have sufficient training to monitor clinical sharing agreements. Although most of the COTRs had general contract monitoring training, they had not received any specialized training on how to establish effective monitoring systems for FTE-based and procedure-based clinical sharing agreements. For example, many of the COTRs were unfamiliar with Medicare-based charges commonly used in procedure-based agreements.

We made seven recommendations to strengthen controls over sharing agreement performance monitoring. The Under Secretary for Health agreed with our findings and recommendations and provided acceptable implementation plans to address the recommendations. VHA is still in the process of implementing the recommendations.

#### Audit of Non-VA Outpatient Fee Care Program

Title 38 of the USC, Sections 1703, 1725, and 1728, permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA facilities, when VAMCs cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. The Non-VA Fee Care Program accounts for the bulk of VHA's purchased care spending with estimated FY 2008 expenditures exceeding \$2.6 billion; it is also VA's fastest growing purchased care activity. For example, outpatient fee costs have more than doubled during the 4-year period FY 2005–2008, from \$740 million to \$1.6 billion, and in FY 2009, outpatient fee costs were just under \$2 billion.

Our recently issued audit report focused on the Outpatient Fee Care Program. In FY 2008, 137 VAMCs processed an estimated 3.2 million outpatient fee claims. These claims were for a wide range of diagnostic and therapeutic services including visits to primary care physicians, x-rays and diagnostic imaging procedures, chemotherapy and radiation therapy, dialysis, physical therapy, and outpatient surgical procedures. Based on our review of a statistical sample of 800 claims, we concluded that VHA had not established adequate management controls and oversight procedures to ensure that claims for outpatient fee services were accurately paid, justifications for services were adequately documented, and services were properly pre-authorized.

- VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimated that in FY 2008, VAMCs overpaid \$225 million and underpaid \$52 million to fee providers, or about \$1.13 billion in overpayments and \$260 million in underpayments over 5 years.
- For 80 percent of outpatient fee claims we reviewed VAMCs did not adequately document justifications for use of outpatient fee care or properly pre-authorize services as required by VHA policy, thereby increasing the risk of additional improper payments. However, our audit did not assess or question the clinical necessity of services.

We concluded that the improper payments, justifications, and authorizations occurred because VHA had not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. We identified three specific areas that required strengthening:

- **Develop Comprehensive Fee Policies and Procedures.** VHA does not have a centralized source of comprehensive, clearly written policies and procedures for the Fee Program. Instead, fee supervisors and staff must rely on an assortment of resources including the Code of Federal Regulations, outdated VA policy manuals, and other procedure guides, training materials, or informal guidance.
- **Identify Core Competencies and Require Training for Fee Staff.** Because the Fee Program is very complex and requires significant judgment by fee staff to ensure correct payments, processing fee claims requires specialized knowledge and skills, such as understanding medical records, insurance billing concepts, and medical procedure coding. However, VHA does not require fee staff or their supervisors to attend initial or refresher training.
- **Establish Clear Oversight Responsibilities and Procedures.** Strong oversight of the Fee Program should include procedures and performance metrics for assessing compliance with program requirements, conducting risk assessments, assessing program controls, and monitoring accuracy and quality of claims processing. However, no one from VHA's Chief Business Office, National Fee Program Office, Veterans Integrated Service Networks, or Compliance and Business Integrity Office is routinely performing oversight activities of the Fee Program.

We made eight recommendations to strengthen controls over the Outpatient Fee Care Program. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans to address the recommendations. In his response, he also stated that information technology (IT) gaps were "key drivers in the erroneous payments" identified by our audit. He pointed out that fee staff manually process many claims and that few upgrades have been made to the VistA Fee system in the past 10 years. As part of our ongoing audit of inpatient fee

care, we are examining the Under Secretary's concern about IT gaps and assessing the impact of IT systems on claims processing accuracy and efficiency.

## **CONCLUSION**

While purchasing health care services from non-VA providers may afford VHA flexibility in terms of expanded access to care and services that are not readily available at VAMCs, it also poses a significant risk to VA when adequate controls are not in place. With non-VA health care costs of about \$4.8 billion in FY 2008 and future costs expected to increase, VHA needs to strengthen performance monitoring over clinical sharing agreements and improve controls over claims processing and the justification and authorization of fee services. Without adequate controls, VHA lacks reasonable assurance that it is receiving the services it pays for, that the services are needed, or that the prices paid for services are correct. Furthermore, it does not have the information it needs to assess whether this approach for delivering health care to veterans is efficient and economical.

Mr. Chairman, thank you for the opportunity to discuss these important issues. We would be pleased to answer any questions that you or other members of the Subcommittee may have.