

Office of Inspector General

Summary Report: Audits of VA - Medical School Affiliation Issues

The Veterans Health Administration continues to make progress on affiliation issues and should act on renegotiating affiliation agreements and avoiding special arrangements.

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Office of Inspector General
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Under Secretary for Health (10)

Summary Report: Audits of VA - Medical School Affiliation Issues

1. Over the past 4 years the Office of Inspector General (OIG) has performed a series of audits of various activities related to affiliations between VA medical centers (VAMCs) and medical schools. This report summarizes the results of these audits and presents our current observations on affiliation issues.
2. An affiliation is an association between a VAMC and a medical school, with varying degrees of interaction and interdependence in patient care, medical education, research, and sharing of staff and other resources. Affiliations are generally recognized as improving the quality of VA healthcare and as increasing medical school opportunities in medical education and research. Today, 75 percent of VA's 173 medical centers have major affiliations with medical schools; about 70 percent of VA staff physicians have medical school faculty appointments; and about 9 percent of medical residents trained in the U.S. are funded by VA.
3. We concluded that the Veterans Health Administration (VHA) has made significant progress in addressing the affiliation-related issues identified by our audits. VHA management has demonstrated their attention to affiliation issues by their responsiveness to our audit recommendations and by their initiatives to restructure the VA healthcare system. However, improvements can still be made at the VAMC level to respond to VHA management initiatives. Further, we believe it is appropriate at this time to work toward eliminating questionable "special arrangements" with medical schools and to renegotiate existing affiliation agreements.
4. VHA has taken action on the three broad issue areas covered by our audits -- management of physician resources, contractual relationships with medical schools, and management information and resource allocation. To address audit concerns about physician and resident accountability, VHA issued guidance reminding VAMC officials of the attendance requirement for part-time physicians and is in the process of issuing new guidance to clarify resident compensation and attendance requirements. To improve the process of contracting for clinical services with affiliates, VHA strengthened policy on scarce medical services contracts, provided training to VAMC contracting staff, and simplified sharing agreement requirements.
5. As part of its restructuring effort, VHA has undertaken several initiatives to address the management information and resource allocation concerns that underlie many of the audit issues. The most important of these initiatives are the establishment of capitation-based budgeting, the implementation of the Decision Support System, and the development of improved performance measurement information. In addition, VHA has established the Residency Realignment Review Committee and the Research Realignment Advisory Committee, which have made

recommendations for targeting education and research resources to meet VA's future healthcare needs. VHA is also considering renegotiation of the existing affiliation agreements.

6. While VHA management has been energetic in addressing affiliation-related issues, the response at the VAMC level has been mixed. Some VAMCs have quickly implemented new VHA policies and directives, but others have been slower to respond, and some problems persist. By following through on their efforts to implement audit recommendations and restructuring plans, VHA will be able to address these problems.

7. We believe VHA should pursue two actions to continue the momentum toward improving the balance in VA-medical school relationships. First, we recommended that VHA remind VAMC officials that they should avoid entering into questionable special arrangements with affiliates. Many of the problems identified by our audits resulted from informal arrangements between VAMCs and schools that were not in accordance with VA policy requirements or sound management practices.

8. Second, VHA should pursue the renegotiation of existing affiliation agreements. We believe that VHA could redesign agreements to better reflect the broader scope, the more complex elements, and the economic realities of today's affiliations. We recommended that VHA explore the feasibility of basing agreements on guiding principles that better reflect VA's current priorities and management philosophy. In our opinion, the two recommended actions would provide a means of communicating to officials at all operating levels VA's goals for participating in affiliations and the conditions under which affiliations should operate.

9. In his comments the Under Secretary for Health concurred in the findings and recommendations and indicated that the report accurately reflected VHA's ongoing efforts to strengthen affiliation relations. VHA will issue directives reiterating the need to fully conform with VA laws, regulations, and policy requirements in all agreements or arrangements with affiliates. The directives will highlight some of the issues identified in this report and will provide clarification about appropriate approaches to address affiliation-related contracting and physician management issues. The Under Secretary also indicated that the guiding principles detailed by the OIG are valid and will be incorporated into policy guidance on the proposed renegotiation of standard affiliation agreements. According to VHA's implementation plan, these actions are in process and should be completed by March 31, 1997. We consider the implementation plan to be acceptable and the audit issues to be resolved. We will follow up on the implementation of planned actions.

[Signed]
MICHAEL G. SULLIVAN
Assistant Inspector General
for Auditing

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Introduction

Background

Over the past 4 years the Office of Inspector General (OIG) has performed a series of audits of various programs and activities related to affiliations between VA medical centers (VAMCs) and medical schools. These audits were done to address the balance and economic fairness in affiliations and the level of medical school influence in VA operations. This report summarizes the results of these audits and presents our current perspective and observations on affiliation issues.

For the past 50 years VAMCs have been involved in affiliations with the Nation's medical schools. These affiliations have evolved into complex associations, with varying degrees of interaction and interdependence in patient care, medical education, research, and sharing of staff and other resources. It is generally recognized that affiliations have benefited both medical schools and VA.

Affiliations significantly impact VA's three major healthcare missions -- patient care, research, and education. It is difficult to quantify how much VA and the medical schools contribute to or benefit from affiliated activities. However, using VA budget data we estimated that in Fiscal Year (FY) 1995 VA funding that directly or indirectly supported affiliation activities totaled about \$1.5 billion of VA's \$16.4 billion medical care and research budget. The following Veterans Health Administration (VHA) FY 1995 budget and program information illustrates the scope of VA-medical school affiliations and their related activities:

- Of VA's 173 VAMCs, 130 (75 percent) had major affiliations with medical schools.
- VA funded about 8,900 medical resident positions at an estimated cost of \$341 million. This means that VA supported about 9 percent of all residents training in the U.S.
- Of VA's 14,500 full-time and part-time staff physicians, about 10,100 (70 percent) held medical school faculty appointments.
- About 86 VAMCs had 305 scarce medical specialist (SMS) contracts to purchase about \$49 million in services from their affiliated medical schools. Fifty-seven VAMCs had 196 sharing agreements with affiliates to provide or to purchase services valued at \$50 million.
- VA provided support to about 1,800 research projects. These projects were funded with \$289 million from research appropriations and \$378 million from the medical care appropriation. Most VA research is conducted by investigators who have both VA and medical school faculty appointments.

Audits of Affiliation-Related Issues

In FY 1993 the OIG reviewed VA affiliations with medical schools to evaluate the need for audits of affiliation-related issues. The review was conducted recognizing the mutual benefits of affiliations but also recognizing concerns about balance in affiliation relationships. The thrust of these concerns, which had been expressed by Congress and VA management, was that in some affiliations the medical school had too much influence on VAMC operations.

As a result of our initial review we began a series of audits of affiliation-related issues. The audits focused on affiliation-related resource utilization and contractual relationships. As of September 1996, we had completed 16 audits. The most significant of these audits were:

- Audit of Part-Time Physician Time and Attendance at Affiliated VA Medical Centers (1994)
- Audit of Veterans Health Administration Resource Allocation Issues: Physician Staffing Levels (1995)
- Audit of VA Scarce Medical Specialist Contracts with Medical Schools (1993)
- Follow-up Review of Scarce Medical Specialist Contracts (1995)
- Audit of VA Resident Work Limits Initiative (1994)
- Audit of VA Disbursement Agreements with Affiliated Medical Schools (1994)
- Audit of Allegations of Mismanagement in Radiology Service, VA Medical Center West Los Angeles, California (1994)
- Audit of VA Sharing Agreements with Affiliated Medical Schools (1995)

The information in this report is largely a compilation of the results of our previously published audit reports, with our current observations on the issues identified by those audits. For this report, and to supplement our earlier audits, we performed a review to determine the implementation status of recommendations from the previous audits and to update our perspective on selected affiliation-related issues. We also began another audit to address a new issue -- the use of Intergovernmental Personnel Act (IPA) agreements as an alternative to hiring or contracting for the services of medical school staff.

For More Information

- Additional background information on the history, scope, and mutual benefits of affiliations is provided in Appendix 1, pages 21-25.
- See Appendix 5, page 57, for a list of the OIG audits of affiliation-related issues.

Results and Recommendations

VHA Has Made Progress on Affiliation Issues and Improvement Efforts Continue

VHA has made significant progress in addressing the issues identified by our audits of affiliation activities. These issues may be categorized into three broad themes:

- **Management of Physician Resources.** VAMCs needed to better control and account for time worked and services provided by part-time physicians and residents. In addition, VHA needed to develop processes to ensure that physician staff resources were more equitably distributed among VAMCs.
- **Contractual Relationships with Medical Schools.** VAMCs needed to follow procurement rules and to use sound business practices in negotiating and administering contracts with medical schools.
- **Management Information and Resource Allocation Systems.** VHA needed to improve ineffective management information systems that have limited the evaluation of affiliated VAMC operations and that have hindered efforts to equitably distribute resources and to efficiently produce services.

Our most recent audit work found that VAMC and VHA management have made improvements in and have devoted more attention to all three themes. Progress has been demonstrated by VHA actions responding to specific audit recommendations and by recent VHA restructuring initiatives. The Under Secretary for Health and other VHA top managers have expressed their commitment to allocating resources more equitably among VAMCs, modernizing patient care delivery, emphasizing management accountability, improving information systems, and developing performance indicators for measuring the cost efficiency, productivity, and quality of clinical programs. Although VHA has made progress, some problems persist at the VAMC level, and some new but related issues have emerged. The following sections of this report discuss our audit results in terms of the three themes and present our current observations, conclusions, and recommendations on affiliation issues.

Management of Physician Resources

Part-Time Physician Time and Attendance. Our 1994 Audit of Part-Time Physician Time and Attendance at Affiliated VA Medical Centers concluded that VAMCs needed to improve the monitoring of time worked by part-time physicians. VAMCs generally did not have adequate controls on physician timekeeping, and in some instances this resulted in VAMCs paying for time not worked or services not provided. This could have been prevented if supervisory physicians (clinical service chiefs) had better monitored attendance and if timekeepers and certifying officials had understood that VAMCs should only pay physicians for time they are either on duty or on

properly charged leave. VHA agreed with the audit recommendations and took action to remind VAMC timekeepers, certifying officials, supervisors, and part-time physicians of VA timekeeping procedures and requirements for fulfilling VA tours of duty.

Continuing Problems with Accountability for Physician Work Time. Although VHA management took steps to address physician timekeeping issues, some problems have persisted. During our recent VAMC visits we noted that some of the time and attendance control weaknesses still exist. For example, at one of the two VAMCs visited, some part-time physicians were working schedules different from their official tours of duty, some supervisors were not enforcing the local requirement for physicians to document their time on sign-in sheets, and some timekeepers did not personally know if physicians actually worked their required tours of duty. Although we were able to generally account for physician time by interviewing staff and reviewing clinical schedules, the weak controls could lead to time and attendance problems. In addition to these observations from our recent VAMC visits, it should be noted that the OIG continues to receive allegations of physicians abusing time and attendance requirements. Some of these allegations have been substantiated and others appear to be valid based on preliminary review.

We recently identified a new accountability issue -- the use of IPA agreements to procure physician services from affiliates. It appears that some VAMCs are using IPA agreements in lieu of part-time staff appointments in an attempt to avoid the normal tour of duty and attendance requirements that would apply to staff or contract physicians. We should emphasize that VHA top management did not agree with this use of IPA agreements. When we reported this problem to them, VHA management began immediate corrective action.

VHA Efforts to Improve Accountability for Physician Activities. In response to our audit recommendations and/or as part of overall restructuring initiatives, VHA has taken actions or is considering new approaches that would improve accountability for physician work time. VHA is exploring a performance-based pay system for physicians and is implementing information system improvements that should provide better information on the clinical care and other activities of individual physicians. The following points could be considered in VHA's ongoing improvement efforts:

- Base part-time physician tours of duty primarily on set schedules, especially for staff with appointments of one-half time or more.
- For physician services that have very limited demand or that are difficult to schedule into regular clinic appointment blocks, develop alternatives to staff appointments. Such alternatives could include compensation on a per-procedure or other fee-for-service basis, the expanded use of sharing agreements, or other contractual arrangements.
- Develop policy on the allocation of physician time to patient care versus other activities.
- Use written performance agreements for physicians that clearly spell out the expectations for duties and services to be performed.

- Continue efforts to educate physicians, supervisors, and timekeepers about time and attendance requirements for part-time physicians.

Resident Accountability Issues. There have also been accountability problems pertaining to medical residents in training at affiliated VAMCs. Our September 1994 Audit of VA Disbursement Agreements with Affiliated Medical Schools focused on how effectively VAMCs had ensured that they received the resident services paid for under disbursement agreements. Most of the disbursement agreement payments reviewed were correct for the larger residency programs. However, improvements were needed in the management of resident services and payments for smaller residency programs in which residents did not work full-time at VAMCs. The most significant payment errors occurred because VAMC officials approved payments based on the resident allocation as opposed to the actual level of services received or because they had difficulty applying current VA policy to variations in resident rotation and assignment schedules that had evolved over the years.

We recommended that VHA issue new policy guidance aimed at helping VAMC managers ensure that disbursement agreement payments are correct. The new guidance should: (1) emphasize that by law VA can only pay for resident services actually provided and cannot pay based on the resident allocation; (2) specify which resident assignments and activities are and are not reimbursable by VA; and (3) delineate procedures for prorating costs when resident services are shared among VAMCs and other hospitals. VHA agreed to prepare the suggested guidance, which is now scheduled for issuance in May 1997.

Physician Allocation Issues. Our September 1995 Audit of Veterans Health Administration Resource Allocation Issues: Physician Staffing Levels evaluated VHA policy pertaining to the management of physician resources (about \$1.8 billion annually) and reviewed the distribution of physician staffing among VA medical centers. This audit demonstrated that there were significant disparities in physician staffing among VAMCs with similar workloads, missions, and levels of affiliation. These disparities were most significant among the 64 VAMCs that we classified as highly affiliated, those with large resident training programs and significant research activities.

The extent of the staffing disparities could not be explained by VHA data pertaining to physician time allocated to patient care, education, or research; to the number of residents or physician extenders; or to differences in acuity or complexity of care. The inequitable distribution of staffing occurred because of VHA's reliance on institutionalized historical-incremental budgeting, which has not adequately responded to changing regional demographics, and because VAMCs have not had a physician staffing methodology or detailed operating-level performance indicators that would help them determine the number and type of physicians needed.

We recommended that VHA develop a clinical level benchmarking process for physician staffing and set goals to encourage all VAMCs to move their staffing levels closer to those of the more efficient VAMCs. VHA acknowledged the staffing disparities and the contributing causes but indicated that they did not want to implement a benchmarking process that focused on physician staffing. Instead, VHA proposed addressing the issues through a series of broader management initiatives that are to be implemented during FYs 1996-1998. According to VHA management,

these initiatives will focus on three broad goals: implementation of capitated funding; development of performance-based oversight; and the decentralization of operational management from VHA Central Office to the new organizational structure, the Veterans Integrated Service Network (VISN).

VHA indicated that the initiatives will have mechanisms to link physician staffing resources with work performed and will allow VHA to assess the allocation of these resources among VAMCs in meeting workloads. Some of the features of these mechanisms will be the development or improvement of performance measures, the definition of clinical production units, the capture of data on clinical staff work outputs and resource inputs, and better accounting for the costs of activities other than direct patient care, such as research and medical education. The OIG accepted these plans to resolve the audit issues. We continue to believe that these management initiatives are needed to improve the distribution of physician resources among VA facilities.

Resident Allocation Issues. Our audit of physician staffing levels found that VAMCs with lower patient-to-physician ratios typically had more residents as well as more staff physicians than did VAMCs with higher ratios. This type of variance was indicative of historical VHA resident allocation practices that have tended to favor certain medical schools described by some VHA officials as “centers of excellence.” These practices have supported the status quo and have not facilitated the shift of resident positions to VAMCs that have experienced the largest recent increases in patient care workload. These VAMCs are typically located in the South and Southwest, the “sunbelt” regions of the country. The increases in patient care workload reflect the large migratory inflows of veterans to these regions from other parts of the country. In contrast, many of the VAMCs that had built up large residency training programs over time are located in the regions of the country (such as New England, California, and the Chicago area) that have experienced the largest outflows of veterans. It appears that these VAMCs have been able to maintain their larger residency training programs and the resources associated with them, while budget constraints have inhibited the growth of training programs at VAMCs with the largest increases in patient care workloads.

VHA Efforts To Restructure Residency Training Programs. VHA has begun restructuring VA’s residency training programs. The most significant efforts have been an increase in the number of primary care residents and the establishment of a Residency Realignment Review Committee to recommend changes in the management of VA’s residency programs:

- **Increase in Primary Care Residency Training Positions.** As part of the broader initiatives to move VA healthcare to a managed care model, in 1993 VHA established the Primary Care Education Initiative (PRIME) to expand primary care training programs. In recent years VHA had provided most of its support to specialty and subspecialty residency programs. For example, in Academic Year (AY) 1993-94 about 65 percent of VA resident positions were allocated to specialty programs such as anesthesiology and cardiology, and 35 percent were allocated to primary care programs, such as internal medicine and family practice. In AYs 1994-95 and 1995-96 PRIME provided an additional 604 resident positions to VAMC primary care training programs. By adding these positions, VHA increased the proportion of primary care resident positions to almost 40 percent of total resident positions.

- **Residency Realignment Review Committee.** In December 1995 the Under Secretary for Health convened the Residency Realignment Review Committee. The Under Secretary charged the Committee with making recommendations for realigning VHA residency programs to meet VA's present and future healthcare needs. In its May 1996 report to the Under Secretary, the Committee made recommendations in two areas: (1) to further expand primary care training, the Committee recommended the elimination of 250 specialty and subspecialty resident positions and the reallocation of 750 positions to primary care disciplines over the next 3-5 years; and (2) to improve the resource allocation process, the Committee recommended the establishment of a new two-tiered national/network advisory structure and the development of performance-based resident allocation criteria.

Implementation of Recommendations to Improve Residency Programs. In our opinion, the Committee's plan provides a reasonable framework for addressing VA residency program issues. The recommended actions would further reduce the number of specialty residents and increase primary care training opportunities. The national and network-level advisory bodies would provide for the participation of medical schools in residency program management and oversight. The development and use of performance-based allocation criteria should provide the basis for more equitable distribution of residents to networks, VAMCs, and individual training programs. The recommended approaches are sufficiently flexible to fit into the broader VHA restructuring initiatives. The proposed 3-5 year implementation timeframe is reasonable given the need to coordinate these changes between VAMCs and affiliated medical schools.

The Committee's plan, if combined with appropriate resource incentives, could promote the shift of resident positions to VAMCs that have experienced the largest increases in patient care workloads. This would allow those VAMCs to benefit from the increased clinical services and cost efficiencies that have been attributed to larger residency training programs. Implementation of the Committee's recommendations would help VHA meet the intent of the prior OIG recommendations from the 1995 Physician Staffing audit. Reallocating and reducing resident positions and developing allocation criteria would be in line with our recommendation to base staffing allocation decisions on performance measures, not on historical-incremental budgeting.

Contractual Relationships with Medical Schools

Scarce Medical Specialist Contracts. Scarce medical specialists are medical professionals who are difficult for VA to recruit and retain. To fulfill VA's healthcare delivery requirements, VHA is authorized to award noncompetitive SMS contracts to affiliated medical schools. Our March 1993 Audit of VA Scarce Medical Specialist Contracts with Medical Schools found that VAMCs did not effectively negotiate or administer SMS contracts. VAMCs usually did not comply with the requirement to use certified cost or pricing (C/P) data for establishing prices on SMS contracts costing more than \$100,000, and as a result often paid more than necessary for SMS services. We estimated that in FY 1992 VAMCs paid about \$14.5 million in excessive charges on SMS contracts with total costs of \$101.2 million.

In addition, the integrity of the SMS contracting program was threatened because VAMCs generally did not meet requirements pertaining to recruiting scarce specialists, determining the

number of contract staff needed to meet workloads, avoiding conflicts of interest, awarding non-competitive contracts to organizations not affiliated with VA, obtaining pre-award audits, and monitoring contract physicians to determine the actual amounts of time worked or services provided. Some VAMC and medical school officials did not take the contracting process seriously. Often, procurement regulations were not followed and prudent business practices were not used in negotiating or administering contracts with affiliates.

To correct SMS contracting deficiencies, we recommended that VHA develop better procedural guidance for SMS contracts and monitor VAMC compliance with this guidance. Most importantly, VHA needed to aggressively enforce the requirement that non-competitive SMS contracts must be based on C/P data.

In response to our audit VHA made a major effort to improve SMS contracting by issuing detailed policy guidance, providing training to VAMC contracting staff, and performing a one-time review of all active SMS contracts. Our May 1995 Follow-up Review of Audit of Scarce Medical Specialist Contracts With Medical Schools found that VHA's actions were effective. We found no significant deficiencies in the contracts reviewed on the follow-up audit.

Although VHA has made significant progress, our recent audit work identified two issues which indicated that VHA needs to continue emphasizing the importance of using sound procurement practices and following contract integrity requirements. These issues were (1) the questionable use of IPAs instead of SMS contracts to procure specialized services from affiliates and (2) continuing weaknesses in VAMC contracting practices:

- **Use of IPAs Instead of SMS Contracts.** In the past 2-3 years, some VAMCs have begun using IPA agreements to obtain physician services that should have been procured through SMS contracts. These VAMCs appear to have adopted the use of IPAs to circumvent SMS contracting requirements. Our recent review of the use of IPAs at one VAMC found that the VAMC was paying significantly more by using IPAs than it would have paid using properly negotiated and administered SMS contracts. We are concerned that the use of IPAs indicates a questionable response on the part of some VAMCs to VHA's substantial efforts to reform SMS contracting practices.
- **Continuing Weaknesses in SMS Contracting.** Our recent audit work indicated that some responsible VAMC staff may still not fully understand SMS contracting requirements. In reviewing an anesthesiology services contract at a highly affiliated VAMC, we found two problems. First, contract monitoring procedures were not adequate to ensure that the VAMC received the services paid for. Second, there was an apparent conflict of interest because the employee who certified contract payments was supervised by a physician who was himself paid under the contract. (As a result of the review, the VAMC took action to correct both problems.)

Sharing Agreements. Sharing agreements (SAs) are contracts between VA healthcare facilities and non-VA hospitals, research centers, or medical schools to buy, sell, or exchange the use of specialized medical services. Our September 1995 Audit of VA Sharing Agreements With Affiliated Medical Schools evaluated how effectively VHA managed sharing agreements with

affiliated medical schools. This audit was performed after our audit of SMS contracts, and we found that VHA had applied the lessons learned from that audit and was effectively managing sharing agreements. We reviewed seven large dollar SAs and found that they generally met policy requirements. All seven SAs were properly justified. The VAMCs had performed required workload analyses before awarding SAs, and they had established good controls to prevent conflicts of interest in the negotiation, award, and administration of SAs. The VHA Medical Sharing Office had ensured that all required VACO legal and technical reviews were completed. When required, pre-award audits were obtained before SAs were awarded. SAs were effectively monitored. Bills for services purchased from affiliates were correct. Charges for services sold to affiliates were accurate and amounts owed were collected. Prices for services sold were generally established in accordance with VA policy.

Although we concluded that VHA was effectively managing SAs, we also found that medical schools had difficulty providing reliable C/P data for procedure-based SAs. Because of this, we recommended that VHA revise policy to eliminate the requirement to obtain C/P data for procedure-based SAs and to allow VAMCs to base the agreements on Medicare reimbursement rates in lieu of C/P data. The use of Medicare rates would provide both SA parties with assurance that procedure prices are reasonable and would reduce VA's overall SA costs by about \$3.1 million a year. VHA agreed with the recommendations and in September 1995 issued a directive authorizing the use of Medicare rates in lieu of C/P data. In May 1996 VHA issued another directive reinforcing the policy that Medicare rates should be used as a benchmark for comparative pricing of SA services.

New Conditions that Could Affect the Use of SMS Contracts and Sharing Agreements.

Two recent developments could change how VAMCs use SMS contracts and sharing agreements. These developments are (1) healthcare marketplace changes that have reduced the demand for some specialists and (2) VHA's efforts to restructure the VA healthcare system:

- **Changes in Market Demand for Some Scarce Specialists.** In the healthcare marketplace, the growth of managed care and accompanying pressures to cut costs have resulted in less demand for, and therefore an increase in, the supply of some medical specialists. These changes may allow VAMCs to (1) reduce their reliance on SMS contracts and (2) negotiate more favorable rates. First, the greater availability of some specialists may allow VAMCs to more successfully recruit and hire staff physicians and to reduce the number of SMS contracts. In our audits we questioned the continuing need for the extensive VAMC use of SMS contracts. At many VAMCs these contracts had become institutionalized over time and were no longer based on a true scarcity of specialists or an inability to recruit them as VA staff. Second, when SMS contracts are justified, the increased supply of specialists should provide VISNs or VAMCs with more leverage and should allow them to negotiate more advantageous contract terms or to increase the use of competitive bidding to award contracts.
- **VHA Restructuring Initiatives.** VHA restructuring efforts could have the two beneficial effects of (1) reducing the need for some SMS contracts and (2) providing new contracting and sharing opportunities. First, VHA restructuring efforts to increase managed/primary care and to integrate clinical services within each VISN may result in shifts in workloads or

consolidation of some clinical services that have been provided under SMS contracts. This could present opportunities to eliminate or to reduce the scope of some contracts. Second, and conversely, as part of restructuring efforts VHA is seeking to expand contracting and sharing opportunities with affiliates and with other private and government healthcare providers. The Veterans' Health Care Eligibility Reform Act (Public Law 104-262), which was recently enacted in October 1996, eliminated some legal barriers and expanded VA's authority to share medical services through contracts with community providers. As VHA increases access to primary care and consolidates other clinical activities, there may be circumstances in which contracting or sharing arrangements may be more economical methods of providing services than the use of VA in-house staff and/or facilities.

Need for Continuing Emphasis on Sound Contracting Practices. Continued emphasis to VISN and VAMC officials on the importance of sound procurement practices and adherence to contracting rules is needed because of (1) the continuing contracting problems at some VAMCs and (2) VHA initiatives to provide more clinical services through contracting and sharing with affiliates and other healthcare organizations. In order to protect VA interests and resources, VISN and VAMC managers must ensure that contractual service requirements have been properly determined, costs are reasonable, and services are actually provided.

Management Information and Resource Allocation

On all of our affiliation audits we observed that VHA did not have adequate management information systems for controlling and allocating resources. The need for good management information is particularly important at affiliated VAMCs because of their large budgets and complex organizations and because of the need to ensure equity in sharing the costs of affiliation programs and activities.

Currently, VAMCs do not have adequate management or accounting systems to capture information on resources (inputs), workload (outputs), or results (outcomes). The existing systems do not have the capability to distinguish the costs associated with various VAMC activities, such as patient care, research, and education. Because of this, they cannot measure performance or identify inefficient or ineffective practices. The absence of good management information systems has made it difficult for VHA managers to evaluate operations and as a result has hindered efforts to achieve either equitable distribution of resources or efficient production of services. The following examples illustrate the problem of inadequate management information:

- **Resident Work Limits (RWL) Initiative.** Our September 1994 Audit of VA Resident Work Limits Initiative found that management information deficiencies contributed to VAMCs receiving RWL Initiative funding that either was not needed or was not used for the intended purpose of complying with new accreditation standards and improving resident working conditions. Based on VHA's estimates of needed funding, Congress provided \$219.1 million for the RWL Initiative in FYs 1992-1994. However, the audit found that VHA and VAMCs did not have accurate or complete records documenting the extent of noncompliance with RWL standards. As a result, VHA overestimated the funding necessary for VAMCs to achieve compliance with standards on resident work hours, supervision, and

ancillary duties. In fact, the evidence indicated that most VAMCs were already in compliance before the RWL Initiative. The allocation of RWL funds followed historical-incremental budgeting patterns, with VAMCs that already had the greatest resources receiving higher proportions of RWL funds.

In addition, VHA did not develop meaningful data or performance measures to ensure that RWL funds were used as intended. VHA's RWL accountability report provided information only on inputs -- the resources received and spent. The report did not provide any substantive information on program outputs, the new staff hired, or on outcomes, whether the VAMCs had achieved compliance with RWL standards. We estimated that of the \$219.1 million in RWL funds provided to affiliated VAMCs, about \$147.4 million to \$176.7 million either was not needed or was not used to achieve compliance with the standards. As a result of the audit, VHA did not request an additional \$153.0 million in RWL funds that had been planned for FY 1996 and future budget years.

- **Physician Staffing Levels.** As discussed in our Audit of VHA Resource Allocation Issues: Physician Staffing Levels, VHA and VAMCs did not have reliable data on physician staffing resources. While the data on the number of staff physicians and residents was reasonably accurate, there was no reliable data on physician workloads or outputs or on how physicians allocated their work time to patient care, research, education, and other activities. In addition, VHA had no reliable information on the number of physicians hired under SMS contracts or IPA agreements.
- **SMS Contracts and Sharing Agreements.** When we audited SMS contracts in 1993, VHA did not have a reliable database showing the number of contracts or the cost of these contracts. Because of this, it was necessary for us to obtain the basic data through questionnaires sent to each VAMC. Our 1995 sharing agreement audit found that the VHA data base that summarized the number of VAMC sharing agreements and the value of services purchased and sold was not accurate. As of July 1996, VHA officials acknowledged that they still did not have reliable databases showing the resources associated with SMS contracts, sharing agreements, or other contractual arrangements.

VHA Efforts to Improve Information Used in Resource Allocation. VHA has recognized the limitations of existing data systems and has made the improvement of management information a prominent part of its restructuring initiatives. VHA responses to our audits have indicated that the development of more meaningful management information will be key to their efforts to resolve the audit issues. One of VHA's major efforts to improve the data used in allocating resources was the Resource Planning and Management (RPM) system, which VHA had been implementing over the past 3-4 years.

Use of RPM in Resource Allocation. RPM was a new methodology intended to improve the distribution of resources and to better define resource requirements. However, the General Accounting Office (GAO) and the OIG have expressed concerns about how effectively VHA was using RPM to allocate resources. In a February 1996 report, VA Medical Resources Allocation System, GAO concluded that RPM did give VHA the ability to identify inequities in resource distribution and to forecast workload changes but that VHA had not used the RPM system to

make significant resource redistributions. Our own analysis showed that for FY 1994 VHA reallocated only \$10 million from higher cost VAMCs to lower cost VAMCs and for FY 1995 reallocated only \$20 million. The \$20 million adjustment accounted for only 0.13 percent of VHA's \$16 billion medical care budget. VHA officials told us that VHA and VA top management had been reluctant to make the more extensive reallocations indicated by the data because VHA was still refining the RPM methodology and did not want to cause severe disruptions at the facilities that would have incurred the largest reductions in funding.

For FY 1996, VHA had intended to increase the reallocations from higher cost to lower cost facilities using "blended rates." Blended rates are composites of individual facility, peer hospital group, VISN, and national cost rates that would decrease funding for facilities with higher unit costs and increase funding for facilities with lower unit costs. The use of blended rates was to serve as a transition to VHA's implementation of a capitation-based resource allocation system. (Capitation is discussed further on pages 13-14.) However, VHA concerns that VISNs and VAMCs needed more time to adjust to blended rate funding levels and the delays in final enactment of the FY 1996 budget limited the funding redistributions.

VHA reported that the blended rate model would have reallocated \$150 million from higher cost to lower cost VISNs. However, to minimize funding shifts during the time the VISNs were being established, VHA capped the FY 1996 reallocations at \$23 million. Although lower cost VISNs received slightly larger budget increases than did higher cost VISNs, these allocations did not significantly close the funding gaps between higher and lower cost VISNs. From our discussions with VHA and VISN officials, it appeared that VISNs had not yet formulated realignment plans for their VAMCs. Therefore, it was unlikely that significant reallocations were made to reduce the funding differences between higher and lower cost VAMCs.¹

New VHA Management Information and Resource Allocation Initiatives. In his 1996 publication, Prescription for Change, the Under Secretary for Health presented a detailed framework for the ongoing restructuring of the VA healthcare system. This framework included various interrelated mission statements, guiding principles, strategic objectives, and actions that covered most VHA functions, programs, and systems. Among these initiatives were a number of planned or proposed actions to address the various management information and resource allocation issues discussed in this report. These initiatives include the system-wide installation of DSS, implementation of ambulatory care data capture, the establishment of capitation-based budgeting, and the development of performance measurement indicators and databases.

Decision Support System (DSS) Capabilities and Implementation. The system-wide implementation of DSS should help VHA improve resource distribution and performance measurement. DSS is a commercially produced relational data base system that will link clinical workload data with resource data from existing VA data sources to provide better management information about clinical care practices and costs. DSS capabilities include the ability to provide

¹ In January 1997 VHA instituted a new resource allocation system, the Veterans Equitable Resource Allocation System (VERA) to replace the RPM system and the blended rate model. VHA indicates that VERA will be used to significantly increase funding reallocations among VISNs during a 3-year phase-in period, FYs 1997-1999.

comparative data for detailed clinical production units and individual practitioners and to aggregate data for roll-up comparisons at facility, VISN, or national levels.

DSS should be particularly valuable in providing better information to help manage the varied and complex activities of affiliated VAMCs. DSS can help managers at all levels to more precisely assess provider production and productivity-efficiency, to accurately account for resources expended in clinical and non-clinical activities, and to determine the actual variation in resource requirements attributable to differences in patient acuity, complexity of care provided, or to the special clinical programs, medical education, or research.

Although DSS appears to have great potential, both GAO and the OIG have recently expressed concerns about the VA information infrastructure from which DSS will derive its source data. In a September 1995 report, Top Management Leadership Critical to Success of Decision Support System, GAO pointed out that some of the data in existing clinical and financial systems were incomplete, inconsistent, and inaccurate, and would limit the effectiveness of DSS in providing relevant and useful management and cost information. In our June 1996 report, Review of Department of Veterans Affairs Cost Accounting Systems, we found that to improve DSS implementation, continued VHA attention was needed to address several issues including: adopting standard industry codes for outpatient services; developing standard methods to calculate workloads; establishing procedures to ensure the compatibility of DSS and other VHA and VAMC system data; and developing guidelines on DSS data reports to meet the needs of managers and other data users.

Implementation of Capitation-Based Budget Allocation. As part of its restructuring plans, VHA has proposed capitation funding as the successor to the RPM resource allocation system. Under a capitated system, VISNs would be funded on a per enrollee basis to provide a defined health care benefits package to each enrolled member. Capitation gives managers incentives to provide care in the most cost-efficient settings, to effectively deliver each episode of care, and to monitor the volume of services provided.

In implementing a capitation-based resource allocation system, VHA will have to address the following three issues that are of particular importance to affiliated VAMCs:

- **Capitation Rates.** To establish capitation funding rates, VHA is considering the use of national base rates with VISN-level adjustment factors for patient risk and geographic cost differences. Risk factors would adjust funding to account for enrollees with medical conditions that are more expensive to treat. Geographic factors would account for differences between higher and lower cost regions. The determination of the national base rate and the weighting of risk and geographic factors are crucial to ensuring equity in resource allocations and to establishing the credibility of the new allocation system.
- **Medical Education and Research Funding.** A major issue for affiliated VAMCs will be how VHA will distribute resources to support medical center education and research in a capitated budget system. The most basic question is whether to allocate all or part of the funding under the capitated rate and rate adjustment structure or to allocate the funding

outside of the capitation system. We believe either approach would be feasible so long as funding decisions are based on performance criteria and take into account actual accomplishments and relative value of the specific activities.

- **Historical Resource Allocation Patterns.** One of the most sensitive issues to affiliated VAMCs will be the shift away from the historical-incremental allocation patterns of the past. VHA's long-standing practice of funding part of medical education and research from the medical care appropriation has contributed to the difficulty of current VHA reallocation efforts. Some of the resource imbalances can be attributed to the concentrations of affiliated VAMCs in certain areas of the country, such as New York City, New England, Chicago, and California. Their historically higher levels of funding combined with shrinking patient populations have resulted in many of these VAMCs having significantly higher per patient funding than other VAMCs. In some cases the disparities in funding levels have carried over to the new VISN organizations.

In our opinion, the primary catalyst for restructuring and improving the efficiency of VA healthcare operations will be the implementation of capitated funding complemented by better performance and unit cost information. Future budget constraints will likely place additional strains on the appropriations that fund the patient care, education, and research missions. Leaner budgets and pressures to improve the equity of veteran access to care and the distribution of resources will result in greater competition for increasingly scarce funds among these missions and among affiliated VAMCs. We have noted that preliminary VISN restructuring efforts have already produced anxiety on the part of some VAMCs and medical schools whose operations might be affected. To clarify mission and funding priorities, VHA should establish policy guidelines on how resources will be distributed to support research, medical education, and other affiliation activities under the new capitated resource allocation system. However, we believe it is important that VHA move ahead and implement capitation and begin making meaningful shifts in resources as soon as possible.

Development and Use of Performance Measurement Information. The successful application of capitation requires that VISN and facility managers have detailed, comprehensive performance measures that can be used to ensure that medical care is provided efficiently, effectively, and within the limits of their capitated budgets. The results of our audits, other reviews, and discussions with VHA, VISN, and VAMC officials have shown that VA information systems currently do not provide the detailed data necessary for this type of management oversight.

In addition to the implementation of DSS and the other initiatives discussed above, VHA has outlined various plans to develop and use performance measurement information in the management of VHA, VISN, and facility operations. The most important initiatives for the issues discussed in the audit reports include: the development and implementation of performance indicators, operating criteria, and databases for the allocation of personnel; the establishment of benchmarks for provider, service line, facility, network, and system level performance; the development of systems to track performance and to provide feedback, and the dissemination of information on best practices and innovations; and the development of clinical performance measures, protocols for comparative information, clinical pathways and guidelines. Other relevant

initiatives include the application of performance expectations and measures to education and research activities, and the improvement of organizational and individual accountability by developing performance-based pay systems for executives and clinicians and by implementing the Government Performance and Results Act of 1993.

Conclusion -- VHA Should Continue Efforts to Address Affiliation Issues

As discussed throughout this report, VHA has made significant efforts to address the various management issues identified in our audits of affiliation activities. VHA top management has issued revised policy and procedures to address major affiliation-related issues, such as SMS contracting and physician time and attendance. Through their restructuring efforts, VHA management has demonstrated a commitment to management accountability and to the efficient use of resources. These efforts should help address underlying affiliation-related issues, such as the need for better allocation of resources and for improved management information systems.

While VHA top management has been energetic in addressing affiliation-related issues, the response at the VAMC operational level has been mixed. Some VAMCs have quickly implemented new VHA policies and directives; others have been slower to respond, and some problems persist. VHA can address these continuing problems by following through on efforts to ensure that audit recommendations are implemented and that restructuring plans are completed. In addition, to continue the momentum toward improving the balance in VA-medical school relationships VHA should pursue two actions: (1) remind VAMC officials that they should avoid questionable “special” arrangements with affiliates that do not meet VA policy requirements; and (2) pursue the renegotiation of affiliation agreements, using guiding principles that reflect VA’s priorities and management philosophy.

Avoiding Questionable “Special” Arrangements with Affiliates. A pattern that emerged from our audits was that some VAMCs had made informal, undocumented arrangements with medical schools that were not in accordance with VA requirements or sound management practices. These arrangements typically resulted in VA incurring higher costs for services received from the affiliate or in VA not receiving the services at all. In some cases, the special arrangements had been made many years ago, had become institutionalized, and medical school staff had come to expect the arrangements to continue indefinitely. Once identified, some of these situations have proven difficult to resolve because VAMC management had been involved in making the special arrangement or had acquiesced in it. The following examples illustrate the problems with making arrangements that do not meet VA policies:

- As part of a \$715,000 SMS contract for 3.0 FTEE anesthesiology services, a VAMC agreed to pay for administrative support costs totaling \$107,000 for two editorial assistants, whose main duties were editing and typing research papers and journal articles, and for other various school administrative expenses. These administrative costs were not allowable under the auspices of SMS contracts because these contracts are by definition for “medical services.” VAMC officials had agreed to pay these unallowable costs even after they had been questioned by a pre-award audit. VA efforts to recover the overcharges were hampered because VAMC management had accepted these unallowable costs in the contract price. This

example also shows how difficult it is to change practices once they have become institutionalized -- as late as July 1996 the VAMC was exploring the possibility of using IPAs to hire the two medical school editorial assistants.

- A former VAMC Chief of Staff had reached an informal agreement with a medical school official to pay the salary and benefits costs of 13 radiology residents with the understanding that the school would actually provide only 6 to 7 residents to the VAMC. This practice continued for 5 years until discovered and resulted in VA overpayments to the medical school of about \$1.5 million.

From our discussions with VHA and VAMC officials during the audits, we believe that there were four major factors that had caused these types of special arrangements to be made:

- VAMC officials, often encouraged by medical schools, had the perception that "nurturing" the affiliation was VHA policy that superseded other requirements.
- Decision-makers had professional and financial interests at both institutions and this resulted in inherent conflicts of interest. In effect, these officials "served two masters."
- VAMC officials did not seriously consider any alternatives to using the affiliate's staff to meet VA needs.
- VAMC officials feared that VHA management would not support them if they stood up to unreasonable demands from medical school officials.

In our view, none of the special arrangements identified by our audits were necessary and none of them furthered VA's interests. Instead, the arrangements appeared to have been made to accommodate the schools' interests or to indirectly provide subsidies to the schools. In every case it would have been more advantageous to follow VA policy or to use alternative sources to obtain needed services.

The high proportion of VAMC clinical staff and supervisors who have faculty appointments at affiliated medical schools makes it inherently difficult to avoid all of the potential or actual conflicts of interest that lead to special arrangements. The establishment of VISN-level management oversight and accountability should make it easier to ensure that VA needs are met and that VA resources are safeguarded in affiliations. However, we believe that VHA top management needs to issue guidance emphasizing to VISN and VAMC managers and staff that they should not enter into or endorse informal or special arrangements that do not comply with VA laws, regulations, or other policy requirements.

Renegotiating Affiliation Agreements. During recent discussions on affiliations issues, the Under Secretary for Health indicated to us that he was considering renegotiating existing affiliation agreements and requested our suggestions to improve the current standard agreements. Most existing agreements were signed in the 1970s and follow a standardized format that covers only the responsibilities pertaining to VAMC medical education and training activities.

VHA's ongoing restructuring of the veterans healthcare system provides a timely opportunity to reevaluate and renegotiate affiliation agreements. We believe that VHA should redesign the agreements to better reflect the broader scope, the more complex elements, and the economic realities of today's affiliations. The development of a new model affiliation agreement with guiding principles will enhance this effort. Based on the results of our affiliation audits, we suggested that the following principles be considered in developing a new model affiliation agreement:²

- 1. Patient Care as VA's Primary Mission.** The model agreement should emphasize that by law VA's primary mission is to provide medical care for veterans and that VA's education and research missions will complement the patient care mission but will not take precedence over it. A clear statement of mission priorities in the agreement would communicate the basic principle by which VA will determine the level of resources that can be afforded to each mission, to individual affiliations, and to specific activities within the affiliation.
- 2. VISN Management Structure.** The agreement should recognize the VISN as the organizational unit that will be ultimately responsible for assessing veteran health care needs in the network and for allocating network resources.
- 3. VA Emphasis on Managed/Primary Care.** The agreement should recognize that VA is moving away from traditional hospital-based care to a managed care model that emphasizes primary care in ambulatory and non-institutional settings. Continuing affiliation activities need to be structured appropriately to support the changes in VA healthcare delivery.
- 4. Recognition of Full Scope of Affiliations.** The agreement should cover all major affiliation components and activities, especially medical research, shared services, facilities, equipment, and other resources that support the affiliation.
- 5. Balance and Integrity in Economic Relationships.** The agreement should discuss the concept of balance and integrity in economic relationships. All affiliation activities have costs, benefits, and/or other consequences that affect one or both of the participating parties. The agreement could state that all component programs and activities should be covered by appropriate contracts, memorandums of understanding, performance guidelines, leases, or other written agreements.
- 6. Recognition of Governing Accountability and Performance Requirements.** The agreement should recognize that VA is a Federal entity subject to certain legal and policy requirements that govern its business relationships with other organizations. While recognizing that affiliations are partnerships, VA still must ensure that regulations, policies, and other requirements are followed in the management of affiliation-related resources and activities. For the mutual protection of each party, the agreement could discourage the use of informal, undocumented arrangements in lieu of formal contracts and other agreements.

² We provided these suggestions to the Under Secretary for Health in a more detailed issue paper "Views on Revising VA-Medical School Affiliation Agreements," dated July 30, 1996.

- 7. Affiliation Advisory Groups.** The agreement could allow new, alternative advisory bodies to replace or complement the traditional Deans Committees required by the current agreements. VISN-level advisory groups with representatives of several affiliates may be appropriate to address issues that impact the multiple affiliations that exist within a network. Expanding the scope of these advisory groups could provide constructive forums to identify new opportunities for collaborations and to cooperatively plan to meet future needs.
- 8. VA Advisory Role in Medical School Decisions.** The agreement could contain a provision to ensure that VA management officials are consulted by the medical school on such matters as strategic planning, program direction, or budgetary issues that will affect VAMC operations. Over the years VAMC management may not have had a level of influence in medical school decision-making that was commensurate with VA's contributions to the affiliation.
- 9. Time Period To Be Specified.** The term or expiration date of the agreement should be specified. The term should be a reasonable length of time, such as 3 years, that would allow for periodic reevaluation of the needs and goals of each party and for the renegotiation of the principles and specific elements to be covered by the agreement.

Redesigned affiliation agreements would recognize the growth and expansion of affiliations over the past 50 years and, through this recognition, would promote new ideas and cooperative efforts which are better directed towards VA goals and priorities. We do not think that revising affiliation agreements would unreasonably constrain or inhibit the flexibility of individual affiliations. If the agreements were to remain unchanged and only address education and training issues, then VHA will have missed an opportunity to close a policy gap that has emerged over time. In our opinion, this gap has contributed to some of the inappropriate practices discussed in our audit reports. Developing a comprehensive and unambiguous statement of principles in one document would provide a means of communicating to officials at all operating levels VA's goals for participating in affiliations and the conditions under which affiliations should operate.

For More Information

- A more detailed discussion of physician management issues is provided in Appendix 2, pages 27-41.
- More information on contractual relationships between VAMCs and medical schools is provided in Appendix 3, pages 43-51.
- A more detailed discussion of management information and resource allocation issues is provided in Appendix 4, pages 53-56.

Recommendation 1

We recommend that the Under Secretary for Health:

- a. Develop and issue a policy statement or directive that reminds VA managers and staff that they should not enter into informal agreements or special arrangements with affiliates that do not conform with VA laws, regulations, or other policy requirements.
- b. As part of the process of renegotiating affiliations, consider including the suggested guiding principles in the revised affiliation agreements.

Under Secretary for Health Comments

The Under Secretary for Health concurred in the findings and recommendations and stated that the report accurately reflected VHA's ongoing efforts to strengthen affiliation relations.

Implementation Plan

- a. VHA's Office of Academic Affiliations and Medical Sharing Office will issue directives reiterating the need to fully conform with VA laws, regulations, and policy requirements in all agreements or arrangements with affiliates. The directives will highlight some of the issues identified in this report and will provide clarification about appropriate approaches in addressing affiliation-related contracting and physician management issues.
- b. The guiding principles detailed by the OIG are valid and will be incorporated into policy guidance relating to our proposed renegotiation of standard affiliation agreements. In October 1996 VHA issued the first of several anticipated academic partnership policy instructions. The Office of Academic Affiliations is also in the process of developing additional guidance for the renegotiations and will also consider utilizing these principles.

VHA's implementation plan indicates that these actions are in process and are to be completed by March 31, 1997. (See Appendix 6, pages 59-62, for the complete text of the Under Secretary's comments.)

Office of Inspector General Comments

The implementation plans are acceptable and we consider the audit issues to be resolved. We will follow-up on the implementation of planned actions.

We appreciate the Under Secretary's positive and constructive response to the report. We agree with the Under Secretary when he indicated that some informal or unconventional arrangements with affiliates might be justified in some situations, such as in the case of part-time physicians not rigidly adhering to set tours of duty, because of the exceptional value VA receives in terms of the contribution to patient care. However, we should note that the exceptions cited in our report were clear instances in which VAMCs had paid for physician services not received or physician time not worked. In all of these instances we found that VA had not received any demonstrable benefit or value that justified the expenditures. We did not question any physician activities that were reasonably related to or resulted in some benefit to VA's patient care, education, or research missions.

We believe it is appropriate for VHA to continue exploring alternatives that will allow sufficient schedule flexibility for contract and part-time physicians while ensuring that necessary services are provided and value is received. When the productivity and performance measurement initiatives mentioned in the comments and discussed in the report are implemented, VHA will have the management tools in place to ensure accountability for clinical work force activities and to better demonstrate value. We emphatically support VHA's management improvement efforts in this area.

Background and Scope

Background on VA Affiliations with Medical Schools

For the past 50 years VAMCs have been involved in affiliations with the Nation's medical schools. An affiliation is an association between a VAMC and a medical school, with varying degrees of interaction and interdependence in patient care, medical education, research, and sharing of staff and other resources.

Benefits of Affiliations

Affiliations are generally recognized as improving the quality of health care in VA medical facilities and as increasing medical school opportunities in medical education and research activities. For VA, affiliations improve the quality of veterans health care and help in the recruitment and retention of physicians by:

- Increasing the number of direct care providers through the use of residents and other trainees.
- Reducing staffing costs by using residents instead of higher paid staff physicians. (The savings are somewhat offset by the cost of staff physicians required for teaching and supervision of residents.)
- Providing an academic setting with access to a broader spectrum of medical services, state-of-the-art tertiary care, and the latest medical advances.
- Attracting high caliber staff who are interested in the opportunities for teaching, research, and continuing education.
- Enhancing VA's ability to recruit staff who have completed their residency programs in VA facilities.
- Promoting research which contributes to advances in veterans health care and medicine in general.

For medical schools, affiliations enhance resident training and reduce costs by:

- Providing hospital beds and patients needed to support residency class sizes and accreditation requirements.
- Supplementing medical school staff salaries by hiring faculty as part-time and full-time VA staff physicians or as SMS contract physicians.
- Supporting medical research by funding research projects, furnishing laboratory space and ancillary services, and providing salary support to VA staff/medical school faculty involved in research.

- Purchasing, sharing the cost, or otherwise providing access to high cost medical technology.

Significant Events in History of VA Affiliations

Origin of Affiliations. VA's affiliations program began at the end of World War II. VA leaders knew that the existing hospital system was not prepared to deal with the huge number of veterans who needed medical care. Of particular concern to VA leaders was the shortage of qualified VA physicians to meet the increasing workload. At the same time medical schools were seeking ways to expand graduate medical education to accommodate the post-war demand of thousands of physicians who had gone into the military during the war without completing specialty training.

In 1945 VA leaders proposed the affiliation concept. Public Law 79-293, enacted in January 1946, provided the legal basis for affiliations. The law authorized VA to establish residency training programs, to set up a new personnel system for physicians and dentists, and to formally establish the Department of Medicine and Surgery (now VHA).

To implement the affiliation program, VA issued Policy Memorandum No. 2, "Policy on Association of Veterans' Hospitals with Medical Schools." This memorandum stated that the purposes of affiliations were to provide the highest quality of medical care for veterans and to generally raise the Nation's standard of medical practice by providing facilities for graduate education. The policy made VA responsible for the care of veteran patients and medical schools responsible for graduate education and training.

Policy Memorandum No. 2 also authorized the establishment of a Deans Committee for each affiliation. Composed of senior medical school faculty, the Committees typically exercise considerable influence on medical center operations, primarily through their authority to nominate medical school staff as part-time VA physicians. By 1948, 68 of 125 VA hospitals were affiliated with 58 of the Nation's 78 accredited medical schools, and about 2,000 residents were training in VA hospitals.

Expansion of Affiliations. Over the past 5 decades there have been several significant policy developments that contributed to the growth of affiliations.

- **Medical Research** -- After World War II Federal spending for medical research increased significantly. (For example, National Institutes of Health funding grew from \$5 million in 1945 to \$1 billion in 1966.) Much of this funding went to medical schools affiliated with VA hospitals, thereby increasing the importance of affiliations in the Nation's overall medical research effort.
- **VA Construction Policy** -- In the 1950's and 1960's VA construction policy favored the location of new and replacement VA hospitals near medical schools. Some new medical schools were also built near VA facilities.
- **Statutory Recognition of Medical Education Mission** -- At the urging of the medical school community, in 1966 Congress passed legislation that recognized medical education and

training as part of VA's medical care mission. The legislation also provided statutory authority for Deans Committees, which had operated since 1946 under VA administrative authority. (Veterans Hospitalization and Medical Services Modernization Amendments of 1966, Public Law 89-785.)

- **Scarce Medical Specialist Contracts and Sharing Agreements** -- The 1966 legislation also provided further statutory recognition of VA-medical school relationships by authorizing VA to enter into agreements with medical schools to share specialized medical resources such as equipment, personnel, or space that otherwise might not be available or to increase utilization through mutual use. The law also authorized VA to non-competitively contract with medical schools for the services of scarce medical specialists.
- **Grants to Medical Schools** -- Under the authority of the VA Medical School Assistance and Health Manpower Training Act of 1972 (Public Law 92-541), VA provided 161 grants totaling about \$300 million in FYs 1973-1990 to affiliated medical schools and VAMCs. The grants helped to establish five new State medical schools near VAMCs and to expand and improve existing medical education programs and facilities.
- **Resident Salary Inequities** -- The Veterans Health Care Expansion Act of 1973 (Public Law 93-82) authorized VA to enter into disbursement agreements with affiliated medical schools for payment of resident stipends and salaries. The law was intended to address inequities between resident salaries paid by medical schools and those paid by VA. Under these agreements the affiliated medical school actually administers salary payments and/or fringe benefits to residents working at the VAMC.
- **Statutory Recognition of Medical Research Mission** -- The Omnibus Health Care Act of 1976 (Public Law 94-581) gave statutory recognition to medical research as part of VA's health care mission. This legislation was passed to help protect VA's research funding. Congress was concerned that possible reductions in funding could jeopardize some of the major affiliations and could adversely affect patient care and physician recruitment.
- **Balance in Affiliations** -- The VA Health Care Amendments of 1980 (Public Law 96-330) addressed concerns that some medical schools had become too dominant in affiliations to the detriment of VA. The law contained provisions to better balance the roles of the affiliation partners by requiring increased VA representation on Deans Committees, by improving full-time VA physician pay to reduce reliance on part-time VA physicians/medical school faculty, and by requiring VAMC Chiefs of Staff to be full-time VA employees (but still allowing them to receive outside remuneration from medical schools).
- **Other Affiliations** -- In addition to affiliations with medical schools, VHA has other affiliations with schools of dentistry, optometry, and podiatry. VA medical facilities also provide clinical experience to graduate and undergraduate-level students in over 40 associated health professions, including nursing, psychology, social work, pharmacy, and dietetics. Each year more than 100,000 residents and students receive all or part of their training at VA facilities.

Cost of Affiliation Activities

It is not possible to determine the exact "cost" of the VA affiliation program. Affiliation activities affect VA's three major health care missions -- patient care, research, and education. It is difficult to separate costs for one mission from costs for another, or to determine how much each party, VA and the schools, contributes to or benefits from each activity. Although the cost of affiliations cannot be precisely determined, it is possible to estimate the VA funding that most directly supports affiliation activities. As the following table shows, in FY 1995 this funding totaled about \$1.5 billion, or about 9 percent of VA's \$16.4 billion medical care and research budget:

<u>Budget Category</u>	<u>(Millions)</u>
Education and Training:	
Resident/Fellow Salaries and Stipends	\$341.1
All Other Trainees	37.7
VAMC Instructional Support	238.3
VAMC Administrative Support	<u>\$125.2</u>
Subtotal	\$742.3
Research and Development:	
Medical Care Appropriation Support (Physician/clinician salaries and ancillary support)	377.7
Research Appropriation Project Funding	<u>289.1</u>
Subtotal	\$666.8
Scarce Medical Specialist Services Contracts	49.1
Sharing Agreements (VA purchases)	35.4
Advanced Technology Shared Acquisition Program	0.9
Total VA Support/Shared Resources	<u>\$1,494.5</u>

Source: FY 1997 VA Congressional Budget Submission and VHA program data.

Scope and Methodology

In FY 1993 the OIG reviewed VA affiliations with medical schools to evaluate the need for audits of affiliation-related issues. The review was conducted recognizing the mutual benefits of affiliations but also recognizing concerns about balance in affiliation relationships. The thrust of these concerns, which had been expressed by Congress and VA management, was that in some affiliations the medical school had too much influence on VAMC operations.

As a result of our initial review we began a series of audits of affiliation-related issues. The audits focused on affiliation-related resource utilization and on contractual relationships between VAMCs and affiliates. As of September 1996, we had completed 16 audits. A complete list of the 16 audits is shown in Appendix 5, page 57.

For this report, and to supplement our earlier audits, we recently performed a review at two affiliated VAMCs to determine the implementation status of recommendations from the previous audits and to update our perspective on selected affiliation-related issues. We also evaluated information on VHA plans and initiatives that we considered to be relevant to affiliation issues.

To determine the potential impact of recent VHA initiatives on affiliation issues, we evaluated available information on the initiatives, including the Under Secretary's Prescription for Change, minutes and reports of the Residency Realignment Review Committee and the Research Realignment Advisory Committee, and GAO and OIG audit reports addressing resource allocation and management information issues. To determine the current status of resource allocations we reviewed available VHA data on the distribution of resources for FY 1996 and on medical resident position allocations for AY 1995-96. As necessary, we discussed the initiatives and issues with various VHA officials.

As a result of our recent VAMC visits, we began an audit of a new affiliation-related issue -- the use of Intergovernmental Personnel Act (IPA) agreements as an alternative to hiring or contracting for the services of medical school staff. We are preparing a separate audit report which will discuss our concerns about the uses of IPAs at some VAMCs.

The information in this report is largely a compilation of the results of our previously published audit reports, with our current observations on the issues identified by those audits. Our audit work was performed in accordance with generally accepted government auditing standards.

Physician Management Issues

Our audits identified two significant recurring issues pertaining to physician management: (1) VA medical centers did not have adequate management controls in place to ensure accountability for VA time worked by part-time attending physicians and by residents; and (2) VHA did not have a staffing methodology or operating indicators to help VAMCs determine their physician staffing needs. In response to the audits or as part of initiatives to restructure the VA healthcare system, VHA management has begun actions aimed at addressing physician resource management issues. However, based on our recent reviews and observations, we believe that as VHA makes progress with restructuring initiatives continuing attention to the management of physician resources will be necessary.

Physician and Resident Time and Attendance Accountability Issues

Our audits identified weaknesses in management controls on the time and attendance of part-time attending physicians and for medical residents working at affiliated VAMCs. Part-time physicians and residents normally split their work time or rotate between a VAMC and other affiliated hospitals. A long-standing principle of VA compensation is that VA should only pay for time that part-time physicians and residents are on VA duty or on properly charged leave. VA duty normally requires part-time physicians and residents to be physically present at the VAMC. In some instances, management control weaknesses have resulted in VAMCs paying for time not worked or services not provided.

Part-Time Physician Time and Attendance. Our July 1994 Audit of Part-Time Physician Time and Attendance at Affiliated VA Medical Centers concluded that VAMC monitoring of physician time and attendance needed improvement. The audit results indicated that some physicians did not work their full VA-paid hours or did not work at the VAMC at all. Our review of timecards and related records pertaining to 43 part-time physicians at three highly affiliated VAMCs found that 4 physicians had been paid a total of about \$117,300 for periods of time when they were absent and not charged leave. The most serious case involved two surgeons at one VAMC who were paid for extended periods of time when they did not perform any VA duties. The timekeeper routinely completed timecards showing that the two physicians were present for their assigned hours even though she did not have personal knowledge of the physicians' actual time and attendance. In addition, the service chief did not provide a satisfactory explanation of why he had certified the timecards even though the physicians were not working at the VAMC.

These situations could have been prevented if supervisory physicians (clinical service chiefs) had better monitored attendance and if timekeepers and certifying officials had understood that VAMCs should only pay physicians for time they are either on duty or on properly charged leave. Some physicians acknowledged that they did not feel obligated to work a set schedule so long as they were available or had arranged for alternative coverage. Supervisors, timekeepers, and certifying officials acknowledged that timecards generally reflected scheduled tours of duty and not necessarily actual time worked.

The time and attendance problems identified by the audit could have been avoided. VAMCs have alternatives to appropriately compensate physicians for providing part-time services, including the use of flexible tours of duty, consulting and attending appointments, sharing agreements, or other contracts for services. When time and attendance problems are discovered and reported, they ultimately hurt the affiliation relationship by causing bad feelings and negative publicity and by sometimes resulting in legal action.

VHA agreed with the recommendations from the 1994 audit and took appropriate steps to remind VAMC timekeepers, certifying officials, supervisors, and part-time physicians of VA timekeeping procedures and requirements for fulfilling VA tours of duty.

Continuing Problems with Accountability for Physician Work Time. Although VHA took steps to address physician time and attendance issues, it appears that some problems have persisted. The OIG is currently reviewing or has recently completed reviews of alleged physician time and attendance abuses at several affiliated VAMCs. An April 1996 OIG report described a problem that indicates that situations still exist where part-time physicians are not working the required hours:

A part-time (4/8ths-time) dermatologist did not work all required hours and substituted fellows to perform some of his clinical duties, with the fellows' time intended to count towards his work hour requirement. Over a period of about 3 years, the timekeeper and the certifying official submitted time records for the physician without knowing or verifying his actual hours worked. VAMC clinical supervisors had agreed to this arrangement. Neither the VAMC nor the dermatologist could provide documentation to account for actual hours worked or services performed. The report also raised concerns about the adequacy of supervision for the fellows and about whether they were properly credentialed and privileged for working at the VAMC.

In this case, a more appropriate method of obtaining the required level of dermatology services would have been through a sharing agreement or some other contractual or fee basis arrangement with the affiliated medical school.

During our recent VAMC visits we noted that some of the time and attendance control weaknesses still exist. For example, at one of the two VAMCs visited, some part-time physicians were working schedules different from their official tours of duty, some supervisors were not enforcing the local requirement for physicians to document their time on sign-in sheets, and some timekeepers did not personally know if tour of duty hours were actually worked. Despite these problems, we were able to generally account for physician time through interviews and reviews of clinical schedules and other records.

A New Accountability Issue -- VAMC Use of Intergovernmental Personnel Act Agreements. An accountability issue that has recently emerged is the use of IPAs to hire part-time physicians. Some VAMCs view IPAs as a means of circumventing the normal VA time and attendance rules. The Intergovernmental Personnel Act of 1970 authorizes VA and other Federal agencies to enter into agreements with State and local governments and with universities for the purpose of

allowing the temporary exchange of employees for short periods when the assignments serve a sound public purpose. (5 USC 3371-3376) Under IPA agreements a VAMC obtains an affiliated medical school employee on a detail or temporary assignment and reimburses the affiliate for all or part of the salary and benefits costs of the IPA employee. IPAs have most frequently been used to obtain the services of professional and technical research staff from affiliated medical schools to work on VA research projects for the duration of the projects. This practice has benefited VA by allowing VAMCs to obtain the expertise of a specific individual for a particular project or a limited period of time without the necessity of having to formally recruit and hire the individual as a VA employee. This use of IPAs seems to be reasonable and in our opinion meets the intent of the law.

Our recent audit work found that the number of IPAs has increased at affiliated VA medical centers and that they are being used more frequently to hire physicians providing direct patient care rather than just to obtain technical research staff. We recently performed preliminary audit work at a VAMC that was making substantial use of IPAs to procure physician services from the affiliate. The VAMC had placed 38 medical school surgeons, anesthesiologists, and other physicians on IPAs. Most of the IPAs were for part-time services. The IPAs we reviewed typically contained only a very general description of the services to be provided by the IPA employee and did not specify either a tour of duty to show the hours to be worked to fulfill the time requirement or the specific clinical duties to be performed at the VAMC.

Our review of the available VAMC documentation and interviews with IPA employees found that the VAMC did not receive the levels of services called for under the IPAs. The following example illustrates how the use of IPAs has resulted in continuing problems in accounting for the time and attendance of physicians providing less than full-time services:

The VAMC had established an IPA agreement with the affiliated medical school for a half-time anesthesiologist at a cost of \$6,900 per month (annual costs = \$82,800). Our review covered the 4-month period January - April 1996. To fulfill the half-time service or attendance requirement for this period, the anesthesiologist should have provided 336 hours of service. However, our review of timesheets, surgical logs, and other VAMC records and our discussions with the anesthesiologist found that he actually provided about 226 hours, or about 67 percent of the required time. As a result, for this 4-month period the VAMC overpaid the medical school about \$9,100 for this IPA employee.

The continuing lack of accountability for physician time and attendance was demonstrated by the VAMC's perfunctory billing verification practices; the incomplete, inaccurate, or lack of tour of duty and attendance information; and the position taken by VAMC management to explain their IPA practices. The medical school would typically bill the VAMC for a set amount each month, usually 1/12 of the annual IPA costs, regardless of the actual level of services provided. The VAMC's records of services provided did not support the level of services billed, but reimbursements were not adjusted to reflect recorded attendance or actual services provided. The attendance records were not conscientiously maintained since they were not used as the basis for determining the level of services received. VAMC management took the position that they should not have to account for the actual work time of IPA employees so long as they knew that these

employees or substitute medical school staff were available to be at the VAMC if needed. This arrangement was apparently based on an informal understanding reached between the VAMC Director and the medical school Dean.

Some of the physicians with IPA appointments had previously worked at the VAMC and had essentially performed the same duties, either as part-time employees or as staff covered by SMS contracts. The VAMC's shift away from the more usual methods of providing physician services raises further questions on the propriety of the VAMC's use of IPAs. In our view, this use of IPAs is not a sound management practice. The IPA arrangements described above allowed the medical school and/or the IPA employee to be compensated at VAMC expense at levels that exceeded VA salary caps while at the same time bypassing VA requirements to define the tour of duty, the expectations for attendance, and the specific level of clinical services to be provided at the VAMC. In effect, the VAMC was paying what amounted to a retainer to the medical school in return for an unspecified level of services on an as needed or on-call basis. These arrangements precluded the establishment of more structured oversight with a more precise accounting of services required or time worked.

These IPA practices present the same type of accountability issues that we previously reported for part-time physicians and for SMS contracts. Our concerns about this continuing lack of management accountability and oversight extend beyond just concerns about compliance with the technical requirements and the intent of the IPA program. The more important issue is that some VAMC and medical school officials have apparently used IPAs in order to avoid determining the true level of physician services needed, using the appropriate method to procure services, and ensuring that compensation for services received is reasonable. (IPA costs and services issues related to SMS contracts are discussed in Appendix 3, pages 44-45.)

We should emphasize that top VHA management did not agree with the VAMC's use of IPAs. When we reported these practices to them, VHA management took immediate action to correct the problem at the medical center discussed above by directing the VAMC to review their IPAs to bring them into compliance with program requirements and to ensure time and attendance records were maintained. We are presently preparing a separate audit report which will provide specific recommendations and suggestions for the development of new VHA policy guidance to govern VAMC use of IPAs.

Need for Policy on Physician Time for Non-Patient Care Activities. Based on our audit results and our various discussions with VAMC managers, it is evident that some physicians and school officials do not clearly distinguish between their VA duties and time commitments and their school-related responsibilities. This may have contributed to the types of time and attendance problems described above.

Many physicians at affiliated VAMCs spend significant time in non-patient care activities such as research, medical education, and other various academic activities. VHA has not developed a clear policy or guidelines for determining what portion of physician time and effort should be spent in these activities. VHA and VAMC managers have told us about various informal thresholds that have been used, such as a 30 percent "rule of thumb" for research time or a "60/40

split,” with 60 percent for patient care and 40 percent for research and academics. Some VA physicians have indicated that they were recruited with the expectations of having 50 percent of their time available for research and academics.

The lack of policy on physician time may have contributed to situations that have evolved where some attending physicians provide very little direct patient care. For example, during our March 1993 Survey of VA Medical Center Affiliations with Medical Schools, a clinical supervisor described his clinic as “resident run,” and stated that attending physicians were not routinely required to see patients. Although the part-time physicians were generally available to assist the residents if necessary, they spent most of their time in academic pursuits.

Increased Financial Pressures on Medical Schools Could Impact Physician Time Spent in Patient Care. Recent news reports and journal articles have described the increased financial and operational pressures on medical schools and teaching hospitals. Many academic institutions are facing reduced revenues resulting from increased competition with other providers for patients, lower reimbursements from private and public health insurers, and reduced research funding. Physicians with dual appointments at VAMCs and medical schools are often expected to provide patient care and/or meet teaching, research, and other responsibilities for both institutions. Because of the financial constraints, they might be pressured to devote more time to non-VA revenue-producing services that contribute to the affiliate’s practice plan earnings, that cover hospital costs such as faculty salaries, administration, and overhead, and that support non-revenue generating academic activities, such as research. Some medical schools or departments may demand that more research and other academic pursuits be shifted over to VA-paid time. VHA management should be aware of these possibilities and should stress to VAMC and VISN officials that VA must receive a fair share of physician time for patient care activities.

Continued Efforts to Improve Accountability for Physician Activities. In response to our audit recommendations and/or as part of overall restructuring initiatives, VHA has taken actions or is considering new approaches that would improve accountability of part-time physicians. VHA is exploring a performance-based pay system for physicians, and is implementing information system improvements that should provide better information on the clinical care and other activities of individual physicians and clinicians. These efforts should improve accountability for determining the level of physician services required and at the same time should provide sufficient duty schedule flexibility and fair compensation for actual services provided. We believe that the following points should be considered in VHA’s ongoing improvement efforts:

- Base part-time physician tours of duty primarily on set schedules, especially for staff with appointments of one-half time or more. This will better ensure the availability of physician services when needed and efficient patient scheduling.
- For physician services requiring less than a half-time time commitment or that require flexible, as-needed tours, such as for clinical specialties or subspecialties that have very limited demand or that are difficult to routinely schedule into regular clinic appointment blocks, continue exploring and developing of new alternatives to standard part-time employee appointments. Such alternatives could include appointments with compensation to be set on a per-procedure

or other fee-for-service basis, the expanded use of sharing agreements, or other contractual arrangements.

- Establish a policy statement or guidelines on the allocation of physician duty time to patient care versus other activities.
- Encourage the use of written performance agreements for physicians that clearly spell out the expectations for duties and services to be performed, attendance requirements, or other basis for compensation.
- Inform managers and educate staff at all levels of VAMCs and affiliated institutions on the existing legal requirements for tours of duty and time and attendance for part-time physicians. Informal, off-the-record arrangements should be specifically discouraged.
- Capture information on actual physician work products and activities (such as through the use of Decision Support System applications and patient encounter data), and use this information to provide better management and oversight of physician-provided services.

Accountability Issues for Residents. There have also been accountability problems for medical residents who receive training and provide patient care services at affiliated VAMCs. Our September 1994 Audit of VA Disbursement Agreements with Affiliated Medical Schools focused on how effectively VAMCs had ensured that they received the resident services paid for under disbursement agreements. In FY 1993, the period covered by the audit, 87 VAMCs had disbursement agreements covering about 6,067 residents, with salary and benefits payments under these agreements totaling \$156.6 million. Most VAMC residency training activities are part of integrated programs. In an integrated program residents typically have a series of rotational assignments at the various teaching hospitals that are affiliated with the medical school. VAMCs may pay residents for their VA rotations either directly through the VA payroll system or indirectly through disbursement agreements with medical schools or affiliated hospitals. A disbursement agreement is an alternative payroll mechanism which allows an affiliated medical school to directly administer salary payments and employee benefits for residents training at a VAMC. The VAMC then reimburses the medical school. This reimbursement should be only for the level of resident services actually received by the VAMC.

Reimbursement Problems More Prevalent in Smaller Residency Programs. Most of the VAMC disbursement agreement reimbursements that we reviewed were generally correct for the larger residency programs, which accounted for the larger proportions of residents in training and of agreement costs. However, improvements were needed in the management and oversight of resident services and reimbursements for smaller residency programs in which residents did not work full-time at VAMCs.

We identified overpayments to medical schools in 17 (30 percent) of 56 programs reviewed at three VAMCs. The problems typically occurred in the smaller training programs or rotations where the residents split their work day or work week between a VAMC and other affiliated hospitals. The errors fell into three categories: (1) VAMCs paid for residents who actually worked full time at other affiliated hospitals and who provided no services to VA; (2) VAMCs

paid the full costs of residents who actually worked part-time for VA; and (3) VAMCs paid for "designated residents" who did not always perform VA duties. The most significant errors occurred because VAMC officials approved payments based on their resident allocation as opposed to the actual level of services received or because they had difficulty applying current VA policies to variations in resident rotation and assignment schedules that had evolved over the years. The following examples illustrate this problem:

- A VAMC had a radiology resident allocation of 13 positions. For the academic year reviewed, the medical school billings and supporting assignment schedules showed that the VAMC received the services of 12.5 full-time equivalent residents. The VAMC based its reimbursement on these schedules. However we found that the bills and assignment schedules were not accurate. VAMC rotation schedules and other records showed that only about 6.9 FTEE residents actually worked at the VAMC. VAMC and medical school officials acknowledged that the billings reflected the full resident allocation of 13 positions and not the actual number of residents working at the VAMC. As a result of this practice, the VAMC overpaid \$236,589 for the services of 5.6 residents who did not work at the VAMC. Based on discussions with VAMC and medical school officials the overbillings and overpayments had occurred over a period of 5 years since the inception of the program, and may have totaled \$1.47 million. The practice of paying for more resident services than received was apparently based on an informal "off the record" understanding between the former VAMC Chief of Staff and the former medical school department chairman.
- Another VAMC's gastroenterology (GI) program had an allocation of three resident positions. Each month, the medical school's bills listed the names of three designated residents as working full-time at the VAMC. In practice, however, up to eight different residents worked part-time at the VAMC. The services provided by these residents equated to 2.5 FTEE. The VAMC overpaid \$18,488 for .5 FTEE services that it did not receive. This .5 FTEE shortfall of resident services may have contributed to a backlog in the GI clinic. The clinic operated for a half-day each week and was staffed by three residents (or about .3 FTEE resident services). The clinic had a 6-month patient appointment scheduling backlog. According to clinic staff, the clinic would have had to operate another 1 or 2 half-days per week to eliminate the backlog. It should be noted that the GI clinics at the affiliated hospital did not have backlogs. The GI residency program coordinator stated that he was not aware that the school had to provide the same level of service that it billed for using designated residents. VAMC officials initiated actions to reduce the backlog by providing additional physician coverage at the clinic and by improving the clinic's patient screening and scheduling procedures.

We estimated that in AY 1992-93, VA overpayments to affiliated medical schools totaled about \$7.5 million, the equivalent of about 200 FTEE in resident services that VAMCs paid for but did not receive. We recommended that VHA issue new policy guidance aimed at helping VAMC managers ensure that disbursement agreements are correct. We suggested that the guidance emphasize that by law VA can only pay for resident services provided at the VAMCs and cannot pay based on the resident allocation, and specify what resident assignments and activities are and are not reimbursable by VA. We suggested that the following specific issues be clarified:

- **Resident Allocation vs. Actual Services.** The guidance should make it clear that VA reimbursement should be based on the level of resident services actually received at the VAMC and should not be considered to be a subsidy to the medical school based on the level of the VA-approved resident allocation.
- **Compensable Resident Activities.** The guidance should clarify what assignments or activities are and are not considered VA-compensable activities. The law generally requires that for VA compensation purposes residents should be working at a VA facility and does not appear to allow VA to pay for residents who are performing non-VA clinical or research activities at affiliated institutions.
- **Alternative Work Schedules.** The guidance should allow for more than the single 7-day a week duty basis described in existing agreements. In some specialties, residents may work a 5-day a week clinical schedule. Providing the flexibility to specify more than one duty basis, such as a 5-day basis and a 7-day basis, should help VAMCs more accurately determine the cost basis for resident services based on the actual work schedules of the specific training programs.
- **Prorating Costs for Less Than Full-Time Coverage.** The guidance should require that affiliated programs develop complete and accurate rotation and assignment schedules that clearly establish the levels of resident coverage, including on-call coverage provided to the VAMC, in order to accurately prorate costs based on VA's actual share of the residents' total work schedules. It has become increasingly routine for residents in smaller specialty programs or in other programs requiring continuity of care assignments to split their work week or work day at more than one hospital, or to provide shared after hours or on-call coverage to two or more hospitals at a time. VA's pro rata share of resident costs should be allocated equitably based on the level of services provided under these types of work schedules.
- **Accurate Rotation and Assignment Schedules.** The guidance should emphasize that training program officials need to provide accurate and complete resident rotation and assignment schedules. This will help ensure that VAMCs are aware of the true level of coverage that they are receiving for billing purposes and clinical scheduling. The use of designated residents for billing purposes should be discouraged.

VHA Action to Address Disbursement Agreement Issues. VHA agreed to prepare additional guidance addressing the resident accountability issues discussed above. The original target completion date was March 1995. VHA officials have since reported that other priorities have delayed implementation but now anticipate that the new guidance should be issued to VAMCs by May 1997. Our recent visits to affiliated VAMCs confirmed that the disbursement agreement issues reported in the 1994 audit report still need to be addressed. Although our limited reviews did not identify any significant payment errors or shortages of resident services, we did observe record keeping and billing reconciliation practices similar to those that contributed to the payment errors identified by the previous audit.

Physician and Resident Allocation Issues

Physicians at affiliated VAMCs have a major role in VHA's patient care, medical education, and research responsibilities. In patient care, physicians are primarily responsible for the treatment of patients, including performing examinations, diagnosing diseases and disorders, and developing and managing treatment plans. In medical education, physicians supervise the patient care activities of residents and provide instruction through lectures, conferences, and rounds. In research, physicians serve as investigators in research projects involving clinical medicine, basic science, rehabilitation, and health services. At various times, Congress and VA top management have expressed concerns about the management of physician resources, with the main concern being that the affiliated medical schools may have had too much influence in VAMC physician staffing decisions.

VA Medical Center Physician Staffing Levels. Our September 1995 Audit of Veterans Health Administration Resource Allocation Issues: Physician Staffing Levels evaluated VHA policy pertaining to the management of physician resources and reviewed the distribution of physician staffing resources among VA medical centers. In FY 1993 VAMCs reported employing 19,380 FTEE staff, contract, and resident physicians with salary and benefits costs of \$1.79 billion.³ The audit found that there were significant physician staffing disparities among VAMCs with similar missions and levels of affiliation. The issue of staffing was most significant for highly affiliated VAMCs. For the purposes of this audit, we defined VAMCs with 70 or more residency training positions as highly affiliated. These 64 highly affiliated VAMCs accounted for about 76 percent of total VA physician staffing, 71 percent of physician salary compensation costs, and 62 percent of total VA patients treated. The concentration of physician resources at affiliated VAMCs is attributable to the broader range of specialized treatment services requiring more clinical providers, medical education activities which include residents and supervisory attending physicians, and research being conducted by physician-investigators.

Disparities in Physician Staffing Among Highly Affiliated VAMCs. Within the group of 64 highly affiliated VAMCs, there were large disparities in physician staffing levels, as measured by the variances in VAMC patient-to-physician ratios. The resource distribution of implications raised by the physician staffing disparities can be illustrated by comparing lower patient-to-physician ratio VAMCs with higher ratio VAMCs, as presented in the following examples:

- VAMCs A and B had similar numbers of physicians but had substantial differences in the number of patients treated. VAMC A had 30,655 unique patients treated and 344.8 physician FTEE, for a patient-to-physician ratio of 88.9. VAMC B had 53,238 patients treated and 338.8 physician FTEE, for a ratio of 157.1. With comparable physician staffing VAMC B treated about 74 percent more patients than did VAMC A.

³ FY 1993 staffing data was the most current information available at the time of the audit. Available VHA information indicates that overall patient-to-physician staffing ratios have not changed significantly from FYs 1993-1996.

- VAMCs C and D treated about the same number of patients but had substantially different physician staffing levels. VAMC C had 36,773 patients treated and 422.8 physician FTEE for a patient-to-physician ratio of 87.0. VAMC D had 36,144 patients treated and 216.7 FTEE for a ratio of 166.8. This means that for about the same number of patients treated, VAMC C had almost twice as many physician FTEE.

The extent of the staffing disparities could not be explained by VA data pertaining to physician time allocated to patient care, education, or research; to the number of residents or physician extenders; or to differences in acuity or complexity of care. The inequitable distribution of staffing has occurred because of VHA's reliance on institutionalized historical-incremental budgeting, which has not adequately responded to changing regional demographics and because VAMCs have not had a physician staffing methodology or detailed operating-level performance indicators that would help them determine the number and type of physicians needed.

We recommended that VHA develop a clinical level benchmarking process for physician staffing and set goals to encourage VAMCs to move staffing levels closer to the levels of more efficient medical centers. VHA acknowledged the staffing disparities and the contributing causes but indicated that they did not want to implement a benchmarking process that focused on physician staffing. VHA instead proposed addressing the issues through a series of broader management initiatives that will be implemented during FYs 1996-1998.

VHA Initiatives to Address Staffing Disparities. In response to the audit, VHA management indicated that their proposed management initiatives would focus on three broad goals: implementation of capitated funding, decentralization of operational management to the VISN level, and development of performance-based oversight. VHA indicated that the initiatives would have mechanisms to link physician staffing resources with work performed and will allow VHA to assess allocation of these resources among VAMCs in meeting workloads. Some of the features of these mechanisms will be the development or improvement of performance measures, establishing definitions of clinical production units, capture of data on work outputs and resource inputs of clinical staff assigned to the production units, and better accounting for the costs of activities other than direct patient care, such as research and medical education. The OIG accepted these plans to resolve the audit issues. We continue to believe that these management initiatives are needed to improve the balance of resources allocated to VA facilities.

Resident Allocation Issues. A significant factor in physician staffing levels and variances at affiliated VAMCs is the number of resident training positions allocated to individual VAMCs. VA physician staffing has two components -- the residents and fellows in training and the attending physicians who provide supervision and instruction to the residents and fellows. The more residents a VAMC has in training, the more attending physicians that are needed to be available to supervise them. The highly affiliated VAMCs with the lowest patient-to-physician ratios typically had both more residents and more attending physicians than affiliated VAMCs with higher patient-to-physician ratios. This type of variance was indicative of historical VHA resident allocation patterns that have tended to perpetuate long-standing allocation patterns and to favor certain medical schools described by some VHA officials as "centers of excellence." Allocation practices have tended to favor the status quo and have not facilitated the shift of

resident allocations to those VAMCs that have experienced the largest recent increases in patient care workload. These VAMCs are typically located in the South and Southwest, the “sunbelt” regions of the country. The increases in patient care workload reflect the large migratory inflows of veterans to these regions from other parts of the country.

In contrast, many of the VAMCs that had built up large residency training programs over time are located in the regions of the country (New England, California, the Chicago area) that have experienced the largest outflows of veterans. It appears that these VAMCs have been able to maintain their larger residency training programs and the resources associated with them, while budget constraints have inhibited the growth of training programs at VAMCs with the largest increases in patient care workloads. The resulting regional variance in resident allocations can be illustrated by comparing resident and patient data for VISNs 12 (Chicago, Wisconsin, Upper Michigan) and 22 (Southern California) with data for VISNs 8 (Florida, Puerto Rico) and 18 (Arizona, New Mexico, West Texas). VISNs 12 and 22 are located in areas that have experienced significant decreases in veteran population but whose affiliated VAMCs have generally been able to maintain the levels of their large training programs:

- The VAMCs in VISN 12 had a combined allocation of 679.5 resident positions (ranked 3rd of 22 VISNs) and a ratio of 48.9 residents per 10,000 patients treated (ranked 1st of 22 VISNs). VISN 12 has about 7.6 percent of VA’s total resident positions, but only accounts for about 4.7 percent of VA patients treated. Six of the eight VAMCs in the VISN have affiliations with six different medical schools. Four of these VAMC-medical school affiliations are located in the Chicago area.
- VISN 22 had a combined resident allocation of 757.6 positions (ranked 1st of 22 VISNs) and a ratio of 45.4 residents per 10,000 patients treated (ranked 2nd of 22 VISNs). The VISN has about 8.5 percent of VA’s total residents but only accounts for about 5.6 percent of VA patients. The five VAMCs in the VISN have affiliations with four Southern California medical schools.

VISNs 8 and 18 are located in regions that have experienced significant increases in veteran population but traditionally have had smaller resident allocations. The VAMCs in these VISNs tend to be located farther apart from each other and there are fewer medical schools:

- VISN 18 had a combined allocation of 303.3 resident positions (ranked 15th of 22 VISNs) and the lowest ratio of 20.6 residents per 10,000 patients (ranked 22nd of 22 VISNs). The VISN has only about 3.4 percent of VA’s total residents but accounts for about 5.0 percent of total VA patients. Three of the six VAMCs were affiliated with two medical schools (although most of one VAMC’s residents were part of independent teaching hospital programs and not part of the medical school’s programs).
- VISN 8 VAMCs had a combined allocation of 558.5 resident positions (ranked 5th of 22 VISNs) but had a low ratio of 24.2 residents per 10,000 patients (ranked 19th of 22 VISNs). The VISN has about 6.3 percent of VA’s total resident positions but accounts for about 7.8 percent of total VA patients. Four of the seven VAMCs in the VISN had affiliations with four medical schools.

In FY 1995 VHA officials told us that they had recognized the need and had begun in the past 2 years to reallocate more positions to VAMCs in the areas with the largest increases in veteran population. The Under Secretary established an advisory committee to suggest changes to the management of VHA's residency training program. (We discuss the committee's recommendations on pages 39-41.) One of the significant issues that should be addressed in VHA's management initiatives is the distribution of residents, including consideration of ways to promote the shift of resident positions to VAMCs that have the capacity and capability to provide residency training experiences and that could use additional residents to alleviate clinical staffing shortages.

Resident Allocations Not Filled. Another issue pertaining to the efficient management of resident allocations is that some VAMCs may not be filling their approved resident allocations. Before the beginning of each academic year, VHA's Office of Academic Affiliations (OAA) approves a certain resident allocation for each VAMC, usually with only minor adjustments to the VAMC's requested allocation. Sometimes VAMCs cannot fill all of the allocated positions. For example, fewer residents may have accepted positions in the training program than was anticipated when the VAMC originally made the allocation request. However, VAMCs are often reluctant to report resident vacancies or to return unfilled positions to OAA because of concern that their allocation base for future years could be reduced. The following examples illustrate the problem:

- In AY 1995-96 a VAMC received a total resident allocation of 77 positions, which included an increase of 10 positions from the previous year. However, based on actual disbursement agreement billings, the VAMC filled only about 67 positions, or 13 percent less than the approved allocation.
- As previously discussed on page 30, for several years a VAMC requested and received an allocation of 13 radiology positions but never filled more than 7 of the positions. (We should note that for AY 1995-96, the VAMC reported that they had filled 10 of the 13 positions and had transferred the 3 remaining positions to the VAMC's internal medicine program.)

These practices hinder the efficient management of VA residency positions by preventing the reallocation of unfilled and/or unneeded positions to other VAMCs that could utilize them and by contributing to overstated budget estimates for funding of resident payroll costs. In its efforts to improve national and local oversight of resident programs, VHA needs VAMCs to accurately estimate their resident allocation needs and report actual filled positions.

VHA Efforts To Restructure Residency Training Programs

VHA has begun efforts to reevaluate and restructure VA's role in graduate medical education. The most significant efforts have been the increased support of primary care training programs and the establishment of a Residency Realignment Review Committee to recommend changes in VA's graduate medical education programs.

Training Program Emphasis on Primary Care. In recent years VHA had provided most of its support to specialty and subspecialty residency programs. For example, in AY 1993-94 about 65 percent of VA resident positions were allocated to specialty programs such as anesthesiology and cardiology, and 35 percent were allocated to primary care programs, such as internal medicine and family practice. As part of the initiative to shift VA health care to a managed care model, in 1993 VHA established the Primary Care Education Initiative (PRIME) to expand primary care training programs. In AYS 1994-95 and 1995-96 PRIME provided an additional 604 resident positions in primary care training programs. By providing these additional positions, VHA increased the proportion of primary care resident positions to almost 40 percent of total resident positions and reduced the proportion of specialty program positions to about 60 percent.

Residency Realignment Review Committee Recommendations. In December 1995 the Under Secretary for Health convened the Residency Realignment Review Committee, which was made up of VA and non-VA members with expertise in graduate medical education. The Under Secretary charged the Committee with making recommendations for realigning VHA residency programs to ensure they meet VA's present and future healthcare needs.

In May 1996 the Committee submitted its report to the Under Secretary, making recommendations in two areas. First, to encourage the expansion of primary care training the Committee recommended the elimination of 250 specialty and subspecialty resident positions and the reallocation of 750 positions to primary care disciplines over the next 3-5 years. Second, to improve the resource allocation process the Committee recommended the establishment of a new two-tiered national/network advisory structure and the development of performance-based resident allocation criteria.

The Committee based its recommendations on several assumptions, including: VA's role in providing unique training opportunities for residents; well-supervised residents provide quality, cost-effective care to veterans; recognition of a national oversupply of physicians, especially in specialties and subspecialties; VHA's need to expand its primary care base and to meet the increased demand for ambulatory care; and the reallocation of residency positions should be governed by objective performance measures.

As discussed below, in our opinion the Committee's recommendations provide a reasonable framework for addressing VA resident training program issues:

- **Reduction/Reallocation of Residency Positions.** The elimination/reallocation of positions would result in a 2.8 percent reduction from VA's current level of about 8,900 residency positions and would increase the proportion of primary care training positions from about 39

percent to 50 percent of total VA positions. The Committee's suggested reallocation formula classifies residency programs into four groups, with the level of reduction or reallocation to be based on each group's relative contribution to primary care or to special VA programs. The reductions/reallocations would be phased in by reducing the number of new first-year residents over a 3-year period.

The proposed implementation schedule provides a reasonable timeframe for VAMCs and their affiliated medical schools to make program adjustments, and should not disrupt residents already enrolled. The schedule should correspond with the timeframes for VHA's broader initiatives. During this period VISNs and VAMCs will be reorganizing their clinical programs, and changes in residency programs will have to be coordinated with these efforts.

- **Restructured Resident Allocation Process.** To restructure the process for allocating residents to VAMCs, the Committee recommended a two-tiered review and advisory structure consisting of a national, headquarters-level Residency Oversight Council and VISN-level Network Education Committees. At the national level, the Residency Oversight Council, with VA and non-VA members, would work with OAA to develop performance-based criteria for participating in residency programs and for allocating resident positions to networks. The performance criteria would include such elements as patient care workload, specialty board examination pass rates, accreditation status, and degree of integration with affiliates.

At the network level, the VISN Director would form a network education committee with members from VAMCs and the affiliated medical schools. Using the guidelines developed at the national level, the network group would formulate plans to distribute the network's resident allocation among the various medical centers and training programs. This committee structure allows for medical school participation in the decision-making and oversight process. This recommended two-tiered national/network review process and the use of performance-based allocation criteria have the potential to provide for more equitable allocation of residents among networks, medical centers, and training programs. The recommended plan contains a structure that if combined with appropriate resource incentives could promote the shift of resident positions to VAMCs that have experienced the largest increases in patient care workloads.

Implementing the Residency Realignment Review Committee Recommendations. The recommendations of the Residency Realignment Review Committee appear to be reasonable and achievable. They address resource distribution and program management issues and should fit into VHA's plans for changes to VA's healthcare delivery structure. The recommended actions would reduce the number of specialty residents and increase primary care training opportunities; the national and network-level advisory bodies would provide for the participation of the affiliated medical schools in residency program management and oversight; and the development and use of performance-based allocation criteria should provide the basis for more equitable distribution of residents to networks, medical centers, and individual training programs. The Committee's recommended approaches are sufficiently flexible to fit into the broader VHA restructuring initiatives. The proposed 3-5 year implementation timeframe is reasonable given the need for these changes to be coordinated between VAMCs and affiliated medical schools.

In addition, we should note that implementation of the Committee's recommendations would help VHA meet the intent of the prior OIG recommendations from the 1995 Physician Staffing audit. Reallocating and reducing resident positions and developing allocation criteria would be in line with our recommendation to base staffing and resource allocation decisions on performance measures.

Contracting Issues

Several of our audits focused on VAMC contracting practices for scarce specialized medical services and sharing agreements with medical schools. VAMCs often did not adequately determine what services were needed, ensure that prices were reasonable, or verify that the services paid for were actually received. Often, procurement regulations were not followed and prudent business practices were not used in negotiating or administering contracts with affiliates. Contracts were seen as a formality, and the real agreements and terms were informally agreed upon by officials who did not have contracting authority or who had conflicts of interest.

As a result of our audits VHA made a major effort to improve these contracting activities by issuing detailed policy guidance on SMS contracts and sharing agreements, providing training to VAMC contracting staff, and performing a one-time review of active SMS contracts. However, our recent audit work demonstrates that VHA should continue its efforts to encourage and ensure fairness and integrity in VAMC contractual agreements with affiliates. This continued emphasis on contracting procedures is especially relevant today in view of VHA's efforts to expand the use of contracting and sharing of clinical services with affiliates and other healthcare providers.

Scarce Medical Specialist Contracts With Medical Schools

Scarce medical specialists are medical professionals who are difficult for VA to recruit and retain. In order to fulfill VA's healthcare delivery requirements, VHA is authorized to award non-competitive SMS contracts to affiliated medical schools. Our March 1993 Audit of VA Scarce Medical Specialist Contracts with Medical Schools found that VAMCs did not effectively negotiate or administer SMS contracts. In FY 1992, the period covered by the audit, affiliated VAMCs had 216 SMS contracts with total costs of \$101.2 million.

Need for Compliance With Cost or Pricing Requirements and Contracting Integrity Rules. VAMCs usually did not comply with the requirement to use certified cost or pricing (C/P) data for establishing prices on SMS contracts costing more than \$100,000. In addition, the integrity of the SMS contracting program was threatened because VAMCs generally did not meet requirements pertaining to recruiting scarce specialists, determining the number of contract staff needed to meet workloads, avoiding conflicts of interest, awarding non-competitive contracts to organizations not affiliated with VA, obtaining pre-award audits, or monitoring contract physicians to determine the actual amounts of time worked or the levels of services provided. In addition, some contract physicians spent significant portions of their VA time on non-VA academic activities, which were not specifically covered by the terms of the contracts. The following examples illustrate some of the major issues:

- **Cost or Pricing Requirements.** A VAMC had an SMS contract with the affiliated medical school for 3.0 FTEE anesthesiologists at a price of about \$715,000. Payroll records showed that the school incurred about \$608,000 in compensation costs for the specialists who worked at the VAMC. The difference of \$107,000 was used by the school to provide administrative support for the anesthesiologists' research and academic activities, which were not allowable costs. VAMC contracting staff agreed to the excessive price even though a pre-award audit

had questioned these administrative costs and the school had declined to provide complete and accurate cost and pricing information to support the contract costs.

Another VAMC had a contract with the affiliated medical school for a .75 FTEE radiologist at a price of \$226,302. This price was based on the average compensation of all faculty physicians in the school's radiology department. However, the physician who actually worked at the VAMC was a junior faculty member who received only about \$144,000 in salary and benefits. Because the VAMC did not adjust the contract price based on the compensation costs of the physician who actually provided the services, the school made an \$82,000 profit over the 1-year term of the contract.

- **Conflict of Interest.** A VAMC's Chief of Anesthesiology, a 7/8ths time VA employee, was responsible for much of the day-to-day administration of the \$1.2 million contract for anesthesiology services. Contract payment records showed that he authorized all payments to the school. The Chief was also employed by the school, receiving \$59,000 a year in compensation. We found no evidence that the Chief had intentionally done anything improper. However, his involvement in the contract did violate conflict of interest rules and did have the potential of creating the appearance of impropriety. When we informed VAMC management about this problem, they took immediate corrective action, assigning the Chief's contract monitoring and payment approval duties to an employee who received no remuneration from the school.
- **Contract Performance Monitoring.** VAMC contracting officer's technical representatives (COTRs) are VA employees responsible for ensuring SMS contract services are provided and bills for payment are correct. The COTR for a VAMC's radiology contract required physicians to sign in on each day they worked. However, the sign-in log did not show how long the specialists actually worked at the VAMC on the days they signed in.

The COTR for the radiation therapy contract at another VAMC did not monitor performance at all. The contract staff kept their own logs of the hours they worked. An example of a log entry read "worked 80 hours this month."

We estimated that in FY 1992 VAMCs paid about \$14.5 million in excessive SMS charges. We recommended that VHA develop better procedural guidance for SMS contracts and monitor VAMC compliance with this guidance. Most importantly, VHA needed to aggressively enforce the requirement that non-competitive SMS contracts must be based on cost or pricing data. VHA agreed with the recommendations and provided acceptable implementation plans to address the problems identified by the audit.

VHA Efforts to Improve Management of SMS Contracts. Our May 1995 Follow-up Review of Audit of Scarce Medical Specialist Contracts With Medical Schools found that VHA had taken significant actions to address the recommendations from the 1993 audit and to generally improve the management of SMS contracting. VHA and the Office of Acquisition and Materiel Management had issued new guidance providing detailed instructions on evaluating cost or pricing data and had developed a template and checklists for VAMCs to use when preparing and submitting SMS contracts for approval. The templates and checklists provided a uniform format

for obtaining, evaluating, and presenting C/P data and helped VAMCs ensure that they met SMS program integrity requirements, such as avoiding conflicts of interest and monitoring contractor performance.

Our follow-up reviews at two VAMCs showed that medical center management and staff had a better understanding of SMS contract requirements and had improved contract administration. We did not find any deficiencies in the 11 contracts reviewed at the two VAMCs. Based on the results of our 1995 follow-up review, we concluded that VHA had implemented the recommendations of the 1993 audit and that VAMCs had significantly improved SMS contracting practices.

Sharing Agreements With Affiliated Medical Schools

Sharing agreements (SAs) are contracts between VA healthcare facilities and non-VA hospitals, research centers, or medical schools to buy, sell, or exchange the use of specialized medical services. Our September 1995 Audit of VA Sharing Agreements With Affiliated Medical Schools evaluated how effectively VHA managed sharing agreements with affiliated medical schools. In FY 1994, the period covered by the audit, 51 VAMCs had 119 SAs with affiliates. The total cost of services purchased from medical schools was \$38.6 million and the total value of services sold to medical schools was \$15.1 million.

VHA's Management of Sharing Agreements Generally Effective. We found that VHA was effectively managing sharing agreements with affiliated medical schools. At two VAMCs we reviewed seven large dollar SAs and found that they generally met policy requirements. All seven SAs were properly justified. The VAMCs had performed required workload analyses before awarding SAs, and they had established good controls to prevent conflicts of interest in the negotiation, award, and administration of SAs. The VHA Medical Sharing Office had ensured that all required VACO legal and technical reviews were completed. When required, pre-award audits were obtained before SAs were awarded. SAs were effectively monitored. Bills for services purchased from affiliates were correct. Charges for services sold to affiliates were accurate and amounts owed were collected. Prices for services sold were generally established in accordance with VA policy. We attributed these positive findings in part to the efforts of VHA officials to apply the lessons learned from the previous audits of scarce medical specialist contracts to the management of SAs.

VAMCs Unable to Obtain Cost or Pricing for Procedure-Based Agreements. A significant problem identified by the audit pertained to cost or pricing data for procedure-based SAs. Procedure-based agreements are generally used to buy or sell multiple clinical services on a per-procedure basis. Procedure-based SAs were the most commonly used type of agreement, accounting for about 95 percent of all SAs. At the two VAMCs we audited, we found that they were not successful in obtaining from their affiliates reliable C/P data that demonstrated the reasonableness of proposed procedure prices. The VAMCs had requested this data, but the medical schools could not provide it because their accounting systems were not structured to capture procedure costs. As a result, the VAMCs ultimately accepted medical school price lists in

lieu of C/P data. The contracting staff at both VAMCs successfully negotiated discounts below the listed prices, and the final SAs reflected these discounts.

Use of Medicare Rates to Set Sharing Agreement Prices. We recommended that VHA revise policy to eliminate the requirement to obtain C/P data for procedure-based SAs, to allow VAMCs to base the agreements on Medicare rates in lieu of C/P data. The use of Medicare rates would provide both SA parties with assurance that procedure prices are reasonable. Eliminating the requirement for C/P data, which the schools were unable to meet anyway, would also simplify the SA contracting process and save staff time in negotiating and awarding SAs.

We estimated that using Medicare rates would reduce SA costs by about \$3.1 million a year. Costs could be further reduced by basing SA prices on discounted Medicare rates. In our opinion, many medical schools would be willing to accept discounted rates because for many procedures, they are already accepting prices that are below Medicare rates. In addition, they are operating in a competitive marketplace and may be willing to accept somewhat lower prices in return for the stable and reliable source of revenue provided by SAs. VHA agreed with the recommendation and in September 1995 issued a directive authorizing the use of Medicare reimbursement rates in lieu of C/P data. In May 1996 VHA issued another directive reinforcing that Medicare rates should be used as a benchmark for comparative pricing of services covered by SAs.

Difficulty in Selling Services to Affiliates. The audit also examined the question of why some VAMCs have not been successful in selling available specialized services to their affiliated medical schools. We conducted a telephone and mail survey of 38 highly affiliated VAMCs that did not sell services, including 28 medical centers that reported not selling any services and 10 medical centers that reported high sales of services (more than \$500,000) to their affiliates. We also performed onsite verification work at four of these VAMCs. The survey results showed that the main reason that the VAMCs had not been successful in selling services was lack of demand -- the schools did not need the services that the VAMCs had available.

In their survey responses, management officials at 3 of the 28 VAMCs that were not selling services stated that they did not have any services or resources available to share. However, management at the other 25 VAMCs told us that they had identified some type of procedure, service or resource that was available for sale to the affiliates. In each of the 25 cases, VAMC management told us that the medical schools simply did not want or need the services. Our telephone discussions with medical school officials and procurement staff confirmed that their institutions were capable of providing all the services their patients needed and that they did not need to purchase the services VAMCs had available to sell. Our discussions with staff of the 10 VAMCs that had high sales further confirmed that demand was the only factor that determined a VAMC's ability to sell services to the affiliate.

Continued Emphasis on Contracting Integrity Issues

During our recent visits to affiliated medical centers, we identified two issues that indicated that VHA needs to continue emphasizing to VAMCs the importance of using sound procurement practices and following contract integrity requirements. These issues were (1) the questionable use of IPAs instead of SMS contracts to procure clinical services from affiliates and (2) continuing weaknesses in SMS contracting practices.

Use of IPAs to Bypass SMS Contracting Rules. In the past 2-3 years, some VAMCs have used IPAs to obtain physician services that should have been procured by SMS contracts. By using IPAs, some VAMCs have circumvented the more definitive SMS contract negotiation and administration requirements to formally determine what services are needed and the staffing levels required to provide the services; to attempt conventional recruiting for physicians to work as VA employees before purchasing contract services; to obtain C/P information or otherwise verify the affiliate's actual costs to provide the services; and to monitor and to pay only for the actual services provided. We are concerned about this shift from SMS contracts to IPAs because it indicates a questionable response on the part of some VAMCs to VHA's substantial efforts to reform SMS contracting practices.

As previously discussed on pages 28-30, we are performing an audit of VAMC use of IPAs. The results of our audit at one VAMC showed that the VAMC's use of IPAs did not adequately safeguard VA interests and resources. The IPAs we reviewed typically specified the VAMC's obligation to reimburse the affiliated medical school a certain amount to cover the cost of the IPA employee. However, the IPAs usually did not adequately specify the medical school's obligation to VA. For example, the IPAs did not precisely describe the actual services to be provided or specify the hours to be worked and did not contain accurate data on the affiliate's actual compensation costs for the IPA employee. The following example illustrates the problems with these IPAs:

The VAMC established an IPA with the affiliated medical school for a neurosurgeon. The agreement showed that the affiliate's total salary and benefit cost for the individual was \$200,000. The agreement called for the neurosurgeon to provide services at the VAMC 2 days a week at an annual cost of \$120,000. This would have meant that, based on a 5 day per week clinical schedule, that the VAMC would have paid 60 percent of the neurosurgeon's compensation costs for 40 percent of his available work time. However, the information in the IPA agreement pertaining to the affiliate's costs and level of services to be provided was not accurate. The \$200,000 shown in the agreement as the school's total compensation costs for the neurosurgeon was not correct. Our review of the school's payroll records found that the neurosurgeon's actual compensation was substantially higher than the \$200,000 figure shown on the IPA.

The neurosurgeon did not provide the full equivalent of 2 days per week service that the VAMC paid for. For the 4-month period covered by our review, the neurosurgeon should have provided 35 days or 280 hours of service at the VAMC to meet the 2 days per week service requirement contained in the agreement. Based on the VAMC's surgical logs and

our discussions with neurosurgery staff, the neurosurgeon provided only 38 hours of service at the VAMC during this period. An additional 68 hours of service were provided by other “substitute” medical school physicians with lower salary costs. The combined services provided by the IPA employee and the substitutes totaled 106 hours, or only about 38 percent of the full 280-hour requirement. If the VAMC had reimbursed the medical school based on the actual level of services provided and the actual salary costs of the neurosurgeons who provided the services, as would be required for an SMS contract, then the VAMC’s total cost for the 4-month period would have been about \$20,000, or about 50 percent less than the \$40,000 actually paid to the medical school. VAMC staff did not monitor the level of services actually provided and routinely authorized payment of the \$10,000 billed each month by the medical school.

The VAMC had not performed any analysis to determine the level of services needed under this IPA. Apparently, the only purpose of the specified 2 days a week work requirement and the inaccurate cost data in the IPA was to provide “support” for the agreed-upon reimbursement of \$120,000 and was not considered by either party to represent the actual services to be provided under the IPA.

When we asked about the VAMC’s actual expectations for services under these IPAs, management told us that IPA employees were not expected to provide specific quantifiable services or measurable amounts of time at the medical center. Instead, these IPA employees or substitutes were expected to be available to come to the VAMC whenever a VA patient needed their particular services. In effect, under these IPA arrangements the VAMC paid a retainer to the medical school to provide clinical services on an as needed or an on-call basis instead of establishing a more structured arrangement based on a definitive assessment of services needed and an accurate accounting of time worked or services provided.

Based on our audit work we concluded that the VAMC’s use of IPAs as described above was part of an effort to avoid what the VAMC perceived to be the more restrictive SMS C/P and other contracting requirements and to allow reimbursement covering costs such as indirect administration or general overhead charges that may not have been allowed under SMS contract rules. As previously discussed, the Under Secretary for Health directed the VAMC to review its IPAs and to ensure that IPAs are not being used as substitutes for SMS contracts and that effective management controls are in place.

Continuing SMS Contract Administration Issues. During a recent VAMC visit, we identified two SMS contract administration and program integrity issues that were similar to the issues found in our previous audits. The following examples describe these issues:

A VAMC had a contract with the affiliated medical school to provide 3.675 FTEE of anesthesiologist services at an estimated annual cost of \$641,520. The VAMC did not require the anesthesiologists to sign in or out or to otherwise document their actual contract time spent at the medical center. To account for contract services and to serve as support for the monthly billings, VAMC Anesthesiology Service staff maintained documentation on operating room anesthesiology procedures. However, this

documentation did not account for all services provided under the contract. For example, the August 1995 operating room anesthesiology data supported only 54 percent of the contract hours billed for that month. Anesthesiology Service staff did not document the actual time that contract staff spent performing other duties covered by the contract, such as pre- and post-operative care, pain clinics, consultations, pre-surgical screening, conferences, and committee meetings. These VAMC contract monitoring procedures did not adequately account for actual FTEE and hours of coverage under the contract and provided only a partial accounting of services actually received by the medical center.

For the same SMS contract, the VAMC had a situation which gave the appearance of a potential conflict of interest:

The VAMC's Chief of Anesthesiology Service was a part-time VA employee and a faculty member of the affiliated medical school. He also provided services for the affiliate and received remuneration under the SMS contract. In his role as VAMC service chief he directly supervised the administrative assistant who was the COTR who approved bills for payment under this contract. Although we did not identify any improprieties, this type of arrangement could result in situations where the service chief could inappropriately participate in or otherwise influence the administration and performance monitoring for the contract under which he received remuneration as a contract provider.

When we brought these issues to their attention, VAMC management took immediate corrective actions to address them by requiring contract providers to sign in and out to account for all of their VA time and by reassigning COTR responsibilities to an employee who was not under the supervision of the Chief of Anesthesiology.

New Contracting and Sharing Opportunities

As part of restructuring plans aimed at improving patient care services through greater integration of inpatient and outpatient resources, VHA is seeking to expand contracting and sharing opportunities with affiliates and with other private sector and government healthcare providers. The Veterans' Health Care Eligibility Reform Act (Public Law 104-262), which was recently enacted in October 1996, eliminated some legal barriers and expanded VA's authority to share medical services through contracts with community providers. This expanded sharing authority, along with VHA restructuring and changes in the broader healthcare market, provide opportunities to reexamine the scope of SMS contracts and sharing agreements.

Restructuring Could Change SMS Contract Requirements. The reorganization of VAMCs into integrated VISN networks may affect existing SMS contracting requirements. The shift to managed primary care and the anticipated integration of clinical services within VISNs should provide opportunities to shift workload and possibly to consolidate or reduce the scope of work for some VAMC clinical activities currently utilizing SMS contracts. For example, consolidating subspecialty surgical activities within a VISN could reduce the level of services required or could eliminate the need for some surgical and anesthesia SMS contracts at some VAMCs.

Conversely, VISN consolidations or downsizing of under-utilized activities could provide additional opportunities for procuring necessary services under sharing or other contractual arrangements from affiliates or other providers. There may be situations where obtaining required services through contracting or other sharing or arrangements might be more efficient and economical than maintaining fully resourced VA in-house clinical capabilities.

Healthcare Market Conditions May Reduce Demand for and/or Costs of SMS Contracts.

Recent changes in health care market conditions also may make it easier for VA facilities to recruit scarce specialists or obtain more favorable contract rates. The growth of private sector managed care, discounted and reduced payments by insurers, and increased pressures to reduce health care expenditures have resulted in reduced demand and incomes for some medical specialties. Various articles have reported reductions in medical practice incomes in both teaching and non-teaching settings and have predicted reduced future demand for additional practitioners in some specialties, such as anesthesiology, radiology, and some surgical subspecialties. These changes in demand may allow medical centers to more successfully recruit and hire staff and to reduce their reliance on SMS contracts. For example, one VAMC that was covered in our 1993 audits of SMS contracts recently reported to us that they have been able to hire staff radiologists and have discontinued their radiology contract.

In addition, VHA efforts to expand the number and scope of partnerships with affiliates and other non-VA providers should provide opportunities for more cost-effective contracts and sharing agreements. Even in situations where SMS contracts are justified, the market changes should help VISNs and VAMCs to negotiate more advantageous contract rates and terms and to better enforce SMS contract rates. If affiliates do not want to abide by these rules, then VAMCs will have the more viable alternative of increasing the use of competitive bidding to award clinical services contracts.

Emphasizing Sound Procurement Practices in Contracts with Affiliates. Based on our audit work, we had questioned the continuing need for the extensive VAMC use of SMS contracts. At many VAMCs, SMS contracts had become institutionalized over time and may no longer be based on a true scarcity of specialists or an inability to recruit them as VA staff. Some of these long-established contractual arrangements may have led to expectations on the part of some medical school department officials that the contracts would continue indefinitely with no reductions in reimbursements or examination of the continuing need for the contracts.

Our recent audit work previously discussed above shows that VHA needs to continue emphasizing sound procurement practices and adherence to contracting rules. The use by some VAMCs of IPAs to circumvent SMS contracting rules and continued contract administration weaknesses show that VHA should continue its efforts to promote the concept of fairness and integrity in economic relationships with the affiliates. VA must expect and demand reasonable assurances that contractual service requirements are properly determined, costs are reasonable, and services are provided.

To address these concerns VHA should continue emphasizing to VISN and VAMC managers that they should not enter into or endorse informal or special arrangements that do not conform with

VA laws, regulations, or other requirements, and that VA's special relationship with affiliates does not supersede VA ethics requirements or prohibitions against conflicts of interest.

The high proportion of VAMC clinical staff and supervisors who have faculty appointments at affiliated medical schools makes it inherently difficult to avoid or overcome all potential or actual occurrences when conflicts of interest might occur. To some extent, the establishment of VISN-level oversight of these affiliations and the related procurement activities could provide greater independence and assurances that VA needs are being met and that VA resources are being adequately safeguarded.

Management Information and Resource Allocation Issues

VHA has undertaken several initiatives to address identified weaknesses in management information systems. This appendix presents more detailed information about our perspective on these initiatives.

Resource Planning and Management System

As discussed on pages 11-12, over the past 3 years VHA has been implementing the RPM system. In a February 1996 report, VA Medical Resources Allocation System, GAO expressed concerns about the RPM system's effectiveness in equitably allocating resources. GAO concluded that RPM does give VHA the ability to identify inequities in resource distribution and to forecast workload changes, but VHA has not used the RPM system to make significant resource redistribution.

Our analysis of RPM data and VHA resource allocation decisions agreed with GAO's conclusion. For FY 1994 only \$10 million was reallocated from higher cost VAMCs to lower cost VAMCs, and for FY 1995 only \$20 million was reallocated. The \$20 million adjustment in FY 1995 accounted for only 0.13 percent of VA's \$16 billion medical care budget. In addition, about one-fourth of the FY 1995 medical care budget was not included in the RPM allocation distribution process. VHA officials have told us that VHA and VA top management have been reluctant to make the more extensive reallocations indicated by the RPM data because VHA was still refining the RPM methodology and they did not want to cause severe disruptions in the activities of the facilities that would have incurred the largest reductions in funding.

For FY 1996 VHA planned to substantially increase the funding redistributions from those of previous years by using "blended rates" -- composites of individual facility, peer hospital group, VISN, and national cost rates that would decrease funding for facilities with historically higher unit costs and would increase funding for facilities with lower unit costs. This redistribution was to serve as a transition to VHA's implementation of a capitation-based resource allocation methodology planned for FY 1998. VHA had estimated that using blended rates would have redistributed \$150 million from higher cost to lower cost facilities. However, the actual redistributions may have been mitigated by other adjustments. VHA approved other allocation adjustments in response to concerns about the need for additional facility transition to blended rates and the delays of several months in enactment of the FY 1996 budget legislation. The additional adjustments created funding pools totaling \$132.0 million for the new VISN directors to distribute to VAMCs in their networks and restored \$51.1 million to VISNs where blended rates adjustments would have reduced FY 1996 funding below FY 1995 levels.

The offsetting effects of these 1996 RPM adjustments resulted in relatively small reallocations of resources from higher to lower unit cost VISNs. While the overall funding allocated through the RPM system increased 1.28 percent from FY 1995 to 1996, lower cost VISNs received slightly higher increases averaging 1.62 percent and higher cost VISNs received slightly lower increases averaging 0.99 percent. These reallocations did not significantly reduce the gaps between higher

and lower cost VISNs. For example, in FY 1995 VAMCs in VISN 3 had the highest average unit cost funding of \$5,914 per patient and VISN 18 VAMCs had the lowest average funding of \$2,946 per patient. This means that VISN 3 medical centers were funded at a rate of 2.01 times that of VISN 18. For FY 1996, after all reallocations, VISN 3 received funding that equated to \$5,988 per patient and VISN 18 received \$2,997 per patient. VISN 3's FY 1996 funding was still 1.99 times that of VISN 18, which indicates only marginal progress in reallocating resources.

Ambulatory Care Data Capture

In October 1996 VHA plans to implement new procedures for VAMCs to use in capturing ambulatory care data. Under this initiative, VAMCs will be required to record more detailed information than previously required for each outpatient visit and each patient encounter with a clinical provider. Presently, VAMCs do not maintain comprehensive provider-specific ambulatory care patient information. The minimum data elements to be recorded for each provider encounter will include patient identification, date, time, and place of service, practitioner identification, type, and organization, services provided, and diagnosis/purpose of visit. Information will be recorded in facility DHCP and national data systems using standard healthcare industry procedure and diagnostic codes and descriptions. The data will be formatted for DSS use and will be consistent with information collected by the rest of the healthcare industry.

This effort should provide more detailed, meaningful, and reliable data for use by DSS and other systems applications in performance measurement, resource allocation, case-mix analysis, quality management, continuity of care, and third-party billings. This provider-specific data resembles private sector clinical provider billing information and will provide the type of documentation that will ensure better accountability for the actual levels of services provided and hours worked by part-time and contract physicians and other providers. According to VHA officials, a subsequent project is planned to similarly upgrade inpatient provider encounter information.

Capitation-Based Budget Allocations

As discussed on pages 13-14, VHA has proposed capitation funding as the next method for distributing resources to individual VISNs. Capitation has the potential to eliminate financial disincentives of past budgeting practices and to improve resource distribution. However, one of the most significant issues that VHA will have to address is the carryover of VAMC resource inequities to the VISN organizations. The long-standing practice of funding medical education and research support from the medical care appropriation increases will make this effort more complex and extremely sensitive to the affiliated medical schools. The reason for this is that some of the resource imbalances can be attributed to the concentration of highly affiliated VAMCs that are located in relatively close proximity to each other. As a result, these allocation patterns have carried over to the new VISN organizations. That is, over time some VISNs with concentrations of highly affiliated VAMCs have been funded at substantially higher levels than other VISNs. For example, in FY 1995 VISN 3 (New York City area) VAMCs received medical care appropriation funding that equated to about \$6,992 per VISN-unique patient treated, which was the highest of the 22 VISNs. Other networks with higher funding levels include VISN 12 (Chicago, Wisconsin) at \$6,251, VISN 1 (New England) at \$6,006 per patient, and VISN 21 (Northern California,

Hawaii, Philippines) at \$5,576. Many of the VAMCs in these networks have historically had higher levels of involvement in and funding for research, education, and specialized programs.

In contrast, VISN 18 (Arizona, New Mexico, West Texas) had funding of about \$3,284 per patient. Other networks with lower funding levels were VISN 8 (Florida) at \$4,031 per patient, and VISN 16 (Eastern Texas, Louisiana, Arkansas) at \$4,183. These networks tended to have VAMCs with increasing patient populations, proportionately fewer resources expended in affiliated activities, and a higher proportion of resources allocated to direct patient care activities. These funding distribution variances illustrate the difficulties that VHA will face in setting capitation rates and phasing in funding allocations based on the rates.

Funding of Research and Education Under Capitation. For affiliated VAMCs, one of the most significant capitation issues is how resources will be distributed to support education, research, and specialized programs. Should the resources be allocated as part of the capitated rate and rate adjustment structure or should they be allocated separately from the capitation process? Currently, all of the costs of VA's support to the medical education mission (\$742 million in FY 1995) and over one-half (\$378 million) of the costs of VA-funded research are paid from the medical care appropriation. In our opinion, much of VHA's difficulty in reallocating resources will be related to these two missions.

We recognize that there are different approaches that policy makers could take to manage and distribute resources. If resources were allocated based primarily on a capitated patient basis, then some highly affiliated medical centers with substantial education and research budgets might incur significant resource cuts. On the other hand, if funding for these activities continued to be allocated along historical patterns, then those VAMCs that over the years have established a solid funding base for their academic activities would continue to have the benefit of higher funding levels.

Although reasonable arguments can be made in support of both approaches, we would encourage the adoption of an approach that would to the extent possible provide funding for these activities outside of the patient care capitation rates and that would be distributed based on performance-based criteria. VHA and VISN officials should take into account the actual accomplishments and relative value of specific activities when making funding decisions. For example, the amounts of research support and "protected" investigator time could be based on competitive merit review results or on the amount of direct research funding awarded from VA or external sources. There should be sufficient flexibility to promote special emphasis areas or to encourage broader participation in research by VAMCs.

Regardless of the specific approach used to allocate and manage resources for these activities it is important that better financial accounting, management information, and performance measurement be developed and applied to ensure that VA management priorities are followed to prevent the continued overreliance on historical funding patterns and to promote greater accountability for measured performance outputs and outcomes for the resources provided. This will require better determinations of actual requirements and accounting for actual costs and levels of effort in the different activities. That is, VHA, network, and facility managers must be

able to differentiate between the costs and resources provided to basic patient care versus other activities such as special programs, research, and education.

As previously discussed, the past inequities in resource distributions have carried over to the new network organizations, with some VISNs funded at substantially higher levels than others. From our observations and discussions with VHA officials, VISNs have not been in a position to immediately adjust to a capitation system without potentially causing severe disruption to operations. For example, recent media reports indicate that in one VISN the most preliminary discussions concerning the potential consolidation or reorganization of some administrative and clinical activities of two VAMCs has alarmed the medical schools affiliated with each VAMC. At the same time, we do believe that the principal catalyst to restructuring and improvement in operations will be capitated funding supplemented by more relevant performance measurement and cost information. Thus, it is important that VHA move ahead and begin making meaningful shifts in resources as soon as possible.

Office of Inspector General Audit Reports
on Affiliation-Related Issues

<u>Report Title</u>	<u>Report No.</u>	<u>Date Issued</u>
Survey of VA Medical Center Affiliations with Medical Schools	3R8-A99-050	March 25, 1993
Audit of VA Scarce Medical Specialist Contracts with Medical Schools	3R8-A99-055	March 26, 1993
Audit of Anesthesiology Services Contract, VA Medical Center San Francisco, California	2R8-A99-200	August 28, 1992
Audit of Scarce Medical Specialist Contracts, VA Medical Center Seattle, Washington	2R8-A99-198	September 11, 1992
Audit of Scarce Medical Specialist Contracts, VA Medical Center St. Louis, Missouri	3R8-A99-060	March 8, 1993
Audit of Scarce Medical Specialist Contracts, VA Medical Center Little Rock, Arkansas	3R8-A99-067	March 22, 1993
Audit of Scarce Medical Specialist Contracts, VA Medical Center Birmingham, Alabama	3R8-A99-076	March 25, 1993
Audit of Anesthesiology Services Contract, VA Medical Center Long Beach, California	3R8-A99-091	April 12, 1993
Audit of Radiology Services Contract, VA Medical Center West Los Angeles, California	3R8-A99-111	May 14, 1993
Audit of Part-Time Physician Time and Attendance at Affiliated VA Medical Centers	4R8-A99-074	July 28, 1994
Audit of VA Disbursement Agreements with Affiliated Medical Schools	4R8-A19-116	September 12, 1994
Audit of VA Resident Work Limits Initiative	4R8-A19-137	September 30, 1994
Audit of Allegations of Mismanagement in Radiology Service, VA Medical Center West Los Angeles, California	5R8-A19-023	December 30, 1994
Follow-up Review of Audit of Scarce Medical Specialist Contracts	5R8-A05-057	May 10, 1995
Audit of VA Sharing Agreements with Affiliated Medical Schools	5R8-A05-107	September 28, 1995
Audit of Veterans Health Administration Resource Allocation Issues: Physician Staffing Levels	5R8-A19-113	September 29, 1995

Under Secretary for Health Comments

Department of
Veterans Affairs

Memorandum

Date: December 28 1996

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Summary Report: **Audits of VA-Medical School
Affiliation Issues**

To: Assistant Inspector General for Auditing (52)

1. We have reviewed this summary report and concur in your findings and recommendations. We are pleased that you have recognized the significant progress made by VHA in addressing issues previously identified in your audits. The accompanying action plan responds to the report's two specific recommendations.

2. As your findings confirm, affiliation-related issues are broad in scope and often exceedingly complex. The complexity is magnified for VHA as a system by the fact that the characteristics of our affiliation relationships vary from facility to facility and are often steeped in historical precedent. While recognizing the need for overall guiding principles at the Headquarters level, we strive at the same time to encourage maximum levels of flexibility at the VISN and medical center levels.

3. Your report identifies instances in a few facilities where informal or unconventional arrangements with the affiliate are admittedly questionable. However, there are other situations where such arrangements might be clearly justified. For example, although we agree in principle with your point that part-time physician tours of duty should be based on set schedules, patient care requirements (including non-direct patient care administrative obligations) often supersede rigid adherence to a set time-frame. Defining tours of duty is very problematic, especially for providers who are more than half-time. Our experience has proven that many clinicians who may not be in strict compliance with time and attendance requirements actually provide excellent value in terms of contributing to high quality care for our patients. The value is also apparent when alternative costs of procuring specialized services are considered. We anticipate that tours of duty will become more workable as we develop primary care models where physicians will be responsible for panels of patients. As you are already aware, many of these accountability issues will be resolved when VHA's evolving productivity and

Under Secretary for Health Comments (continued)

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performance measurement initiatives are fully implemented. The Decision Support System (DSS), for example, has developed standard business rules to ensure that costs and volumes of work are recorded in a standard fashion among facilities. This will provide an opportunity for valid comparisons among facilities. DSS has also established detailed guidelines for capturing costs for research support and education and training within the medical care budget.

4. VHA's Prescription for Change calls for review and renegotiation of all academic affiliation agreements and we are actively pursuing this goal. As reported in our action plan, the Office of Academic Affiliations is currently drafting criteria that will be used by the facilities in this process. The suggested guiding principles identified in your report are applicable and will be incorporated into these criteria as appropriate. Each VISN has also designated an academic affiliations officer to assist the Network Director in all aspects of affiliation-related issues. Among other things, this individual will provide guidance, coordination and assistance to individual medical facilities in re-negotiating specific affiliation agreements.

5. We appreciate your assistance and cooperation during the review process and believe your report accurately reflects our ongoing efforts to strengthen affiliation relations. If additional assistance is required, please contact Paul C. Gibert, Jr., Director, Reports Review and Analysis (105E), Policy, Planning and Performance Office (105).

[Signed]
Kenneth W. Kizer, M.D., M.P.H.

Attachments

Under Secretary for Health Comments (continued)

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: Draft Summary Report: ***Audits of VA-Medical School Affiliations Issues***

Report Number: none

Date of Report: none

Recommendations/ Completion Actions	Status	Date
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Recommendation 1

We recommend that the Under Secretary for Health:

- a. Develop and issue a policy statement or directive that reminds VA managers and staff that they should not enter into informal agreements or special arrangements with affiliates that do not conform with VA laws, regulations, or other policy requirements.**

Concur

Both the Office of Academic Affiliations and the Medical Sharing Office will issue directives reiterating the need to fully conform with VA laws, regulations and policy requirements in all agreements or arrangements with affiliates. The directives will highlight some of the issues identified in this report and provide clarification about appropriate approaches in addressing affiliation-related contracting issues, including physician management. Supplemental field guidance will also be provided as necessary to all facility managers during regularly scheduled weekly conference calls conducted by the Chief Network Officer and to the VISN Directors during their joint meetings. The VISN Directors have already been actively involved with affiliation issues. For example, included among the Under Secretary for Health's Academic Partnership Policy Instructions (October 7, 1996) are specific recommendations identified in the VISN Directors' Academic Affiliations Task Force Report, dated September 17, 1996. Each Network Director has also named a Network Academic Affiliations Officer to assist the Network Director in ensuring that individual treatment facilities are provided with necessary guidance and assistance in a broad range of affiliation activities.

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Under Secretary for Health Comments (continued)

Page 2 VHA Response: OIG Draft Report/Medical School Affiliation Issues

- b. As part of the process of renegotiating affiliations, consider including the suggested guiding principles in the revised affiliation agreements.**

Concur

As previously referenced in this action plan, the Under Secretary for Health has already issued the first of several anticipated academic partnership policy instructions. A copy of this document is attached. The guiding principles detailed by OIG are valid and will be incorporated into policy guidance relating to our proposed re-negotiation of standard affiliation agreements. The Office of Academic Affiliations is also in the process of developing additional guidance for the re-negotiations and will also consider utilizing these principles. Prior to finalization of this guidance, VHA will seek input from our academic stakeholders as well as from other knowledgeable individuals within the VA system.

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March 1997

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