CIRCUMVENTION OF CONTRACTS IN THE PROVISION OF NON-VA HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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CIRCUMVENTION OF CONTRACTS IN THE PROVISION OF NON-VA HEALTHCARE

Monday, June 1, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 4:02 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [chairman of the subcommittee] presiding.

Present: Representatives Coffman, Lamborn, Benishek, Walorski, Kuster, O'Rourke, Rice, and Walz.

OPENING STATEMENT OF MIKE COFFMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order.

I want to welcome everyone to today's hearing, titled "Circumvention of Contracts in the Provision of Non-VA Healthcare." This hearing is the second in a series of hearings examining illegal VA procurement practices resulting in massive waste of limited taxpayer resources and serious jeopardy to the quality of healthcare received by our Nation's veterans.

In our previous hearings on procurement on May 14, 2015, we focused on the mismanagement and misuse of purchase cards and avoidance of contract requirements, spending limitations, and warrant authority. VA's Senior Procurement Executive, Mr. Jan Frye, testified that these unauthorized commitments were in the billions of dollars. Mr. Frye has indicated similar levels of mismanagement and abuse in the procurement of non-VA healthcare services by VHA.

By far, the most prevalent method by which veterans receive non-VA care is through the individual authorization, so-called "fee-basis process." Under Title 38 of the Code of Federal Regulations, section 17.52, VA is authorized to obtain non-VA medical services when demand is infrequent and the needed healthcare is not available in-house or through an existing contract. Unfortunately, VA uses this process even when these requirements are not at issue.

Moreover, VA admits that the execution of these authorizations does not comply with the contract requirements of the Federal Acquisition Regulation, or FAR, and Veterans Affairs Acquisition Regulation, VAAR, V-A-A-R.

Mr. Frye will testify that, by the longstanding and massive circumvention of the FAR and VAAR in the fee-basis authorization process, VA has illegally obligated billions of dollars. He will explain that VA incurs billions in improper payments that represent

material weaknesses in VA internal audit controls. Significantly, in 2009 and 2010, the OIG reported on serious problems with the accuracy and efficiency of claims paid through the fee-basis program. The OIG reported that VA medical centers made hundreds of millions of dollars in improper payments, including duplicate payments and incorrect amounts.

Most troubling is that VHA had not established fraud prevention or detection controls because it didn't consider the program to be at significant risk. OIG estimated that VA could be paying as much as $380 million annually for fraudulent claims. And, in May 2014, contrary to VA's assertion that previous illegal purchases can be institutionally ratified, OIG reported that VA further violated the law by institutionally ratifying illegal purchases and avoiding important checks and balances.

Today, GAO director of healthcare Randall Williamson will testify about the continuing limitations in oversight of healthcare service contracts and will focus particularly on the inadequate management of clinicians who provide services under contract with VA facilities.

We will also hear from United States Army veteran Christopher LaBonte, whose horrific experience with VA represents a case study in the risk associated with noncompetitive contracts with affiliates and the importance of quality control and oversight of contract performance standards.

As I said in the purchase card hearing, violations of procurement laws are not mere technicalities. It is not just a matter of paying a little more for needed supplies and services, as some apologists for VA have asserted. Among other things, without competition, businesses may be awarded based on—business may be awarded based on cronyism and the directing of business to favored vendors, including those who may be employees or former VA officials.

Without contracts, patient safety provisions are not legal requirements. VA's mismanagement of the fee-basis program is not a justification to dispense with FAR or VAAR requirements. If the atom bomb can be built and wars conducted under the acquisition regulations, surely VA can deliver patient care under them, as well.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

[THE PREPARED STATEMENT OF CHAIRMAN MIKE COFFMAN APPEARS IN THE APPENDIX]

OPENING STATEMENT OF RANKING MEMBER ANN KUSTER

Ms. KUSTER. Thank you, Mr. Chairman.

This afternoon's hearing is a followup to our hearing 2 weeks ago, and today our focus will be on the legal basis underlying VA's purchase of non-VA healthcare and the practice of VA in obtaining this care.

At the end of the day, we can all agree we want to see our veterans receive the healthcare they need at precisely the moment they need it. But I want to make clear that neither I nor my colleagues view this laudable intent as a blanket rationale for not following laws, regulations, or proper procedure.

Federal and VA acquisition regulations exist for a reason. They exist to ensure that there is proper competition when appropriate

and that the best practice and price possible is obtained when the government purchases goods and services. For the VA, these laws protect veterans, save taxpayer dollars, and ensure our veterans receive the highest possible quality of care.

VA states in its testimony that it has had a 30-year practice of using individual authorizations without applying Federal acquisition processes and procedures. At the same time, it seems that the VA has taken the position that individual authorizations are indeed contracts and should be viewed as such, even when acknowledging that VA officials appear to have acted in a manner inconsistent with procurement law.

Now VA is arguing that it needs new statutory authority, quote, to resolve what has emerged as serious legal questions to its purchased care authorities. This new authority would explicitly exempt VA from procurement regulations and requirements and allow the VA to continue with the same practices that it has been following for the past 30-years.

I personally am not convinced that this is the best solution, given VA's significant lack of oversight in this area. In fact, I would argue that the problem is not that legal questions have arisen over VA's Purchase Care Program but that for too long VA has operated a program where the legal basis has been challenged and yet VA has never changed course or modified its procedures.

VA's authority to purchase care without having a contract in place is predicated on individual authorizations being used, quote, "when demand is only for infrequent use," period, close quote. I would be interested in finding out how much of the $7 billion expenditure for non-VA care in fiscal year 2014 has been obligated under this authority as compared to situations where contracts are in place.

As we examine the current legal authority for VA's Purchase Care Program and whether this authority must be modified, we must first get to the bottom of how this program has been operated over the last number of years. It is absolutely critical that we understand how VA's legal interpretations changed and were communicated and enforced. It is hard to expect accountability when there are no clear signs pointing out the way.

The testimony of Mr. Frye and the various legal arguments made by the VA in litigation makes it seem unlikely that over the last number of years clear policies and procedures were in place. GAO's testimony points out, quote, significant weaknesses in VA monitoring and oversight of its non-VA medical care program.

Perhaps it is now time to stop applying quick band-aids and resolve right now to fix what is wrong. It took years for VA to get into this problem, and it will take time to fix it. But the first step in addressing the problem is to acknowledge these problems and quickly and forthrightly come up with a concrete plan to fix them.

Finally, I would like to thank Mr. LaBonte for appearing before us today to relate his story, which is absolutely horrendous. Mr. LaBonte reminds us that the bottom line is the quality of care for our veterans. This quality can certainly be impacted by lack of accountability and process when it comes to making sure that all relevant laws, regulations, and policies are followed.

And, with that, Mr. Chair, I yield back the balance of my time.

[THE PREPARED STATEMENT OF RANKING MEMBER ANN KUSTER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I ask that all members waive their opening remarks, as per this committee's custom.

With that, we have the first and only panel at the witness table.

On the panel, we have Mr. Edward Murray, Acting Assistant Secretary for Management and Interim Chief Financial Officer of VA Office of Management; Mr. Greg Giddens, Principal Executive Director of VA's Office of Acquisition, Logistics, and Construction; Mr. Norbert Doyle, Chief Procurement and Logistics Officer of the Veterans Health Administration; Ms. Phillipa Anderson, Assistant General Counsel for Government Contracts of VA's Office of General Counsel; Mr. Jan Frye, VA's Senior Procurement Executive and Deputy Assistant Secretary for the Office of Acquisition and Logistics; Mr. Randall Williamson, director of GAO's healthcare team; and Mr. Christopher LaBonte, a United States Army veteran.

I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. COFFMAN. Thank you. Please be seated.

Mr. Murray, you are now recognized for 5 minutes.

TESTIMONY OF EDWARD J. MURRAY, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND INTERIM CHIEF FINANCIAL OFFICER, OFFICE OF MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; JAN FRYE, DEPUTY ASSISTANT SECRETARY AND SENIOR PROCUREMENT EXECUTIVE, OFFICE OF ACQUISITION AND LOGISTICS, DEPARTMENT OF VETERANS AFFAIRS; RANDALL WILLIAMSON, DIRECTOR, HEALTHCARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND CHRISTOPHER LABONTE, UNITED STATES ARMY VETERAN

TESTIMONY OF EDWARD J. MURRAY

Mr. MURRAY. Good afternoon, Chairman Coffman, Ranking Member Kuster, and members of the committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' care to veterans by contracting with community providers.

Mr. Chairman, the subject of this hearing involves some complex territory related to procurement process, legal interpretations, and the processing of hundreds of thousands of purchased care transactions per year. I know we will be discussing these areas in detail and that the committee's oversight is important.

VA will always depend on a mix of in-house and community care, with care in the community continuing to grow to ensure veterans get the care they need in a timely way as close to home as possible. So while the discussion here may be technical, we're discussing transactions that represent the purchase of healthcare for a veteran who needs it.

When purchasing care in the community, VA depends on both Federal acquisition-based contracts and non-FAR-compliant agreements, also referred to as individual authorizations. These agreements are used in many situations because a provider may have

a relatively small number of veterans referred by VA as a part of their total patient mix. For those providers, it may not make business sense for them to enter into a FAR-based contract to provide care. This is especially true in rural areas.

Although these agreements are not FAR-compliant, VA utilizes internal controls to ensure that care is obtained from a qualified provider and the services billed are consistent with VA regulation before a claim is paid. These practices safeguard veterans and protect taxpayer dollars.

The VA's use of community care has risen dramatically. In fiscal year 2006, it was roughly $2.7 billion. For fiscal year 2015, we estimate $10.4 billion.

Over those years, the different authorities for purchased care have not been applied consistently and have been marked by conflicting interpretations. With the determination by the Department of Justice that individual authorizations are contracts and therefore must be FAR-compliant, VA began reviewing its internal processes, working towards development of a plan to improve integration, transparency, and oversight of all purchased care.

We have recognized these problems and proposed a solution. Last year, in informal discussions with committee staff, VA noted issues that would need to be addressed by statute. In February's budget submission, we noted the Department would be putting forward a legislative proposal.

On May 1, we provided a formal proposal for comprehensive reform, including very specific requirements for non-FAR-based agreements. The legislation would authorize the Secretary to enter into veteran care agreements when FAR-based contracts are not practical, with payment rates tied to Medicare rates—similar to community care purchased throughout the Veterans Choice Program.

The legislation recognizes that FAR-based contracts should be used when they can but also allows the responsible use of non-FAR-based agreements. Every 2 years, VA would review all of its non-FAR-based agreements of a certain size and evaluate whether changing to FAR-based contracts is more appropriate.

I believe you will find the legislation provides strong protections for veterans and taxpayers.

Mr. Chairman, we look forward to answering the committee's questions.

[THE PREPARED STATEMENT OF EDWARD J. MURRAY APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Murray.

Mr. Frye, you are now recognized for 5 minutes.

TESTIMONY OF JAN FRYE

Mr. FRYE. Chairman Coffman, Ranking Member Kuster, and members of the subcommittee, thank you for inviting me to testify today.

You just heard Mr. Murray provide the Department's position on the illegal purchases of billions of dollars in non-VA care over multiple years. If you're not now confused, I am surprised. I would be completely confused if I were not familiar with the facts.

We obviously do not intend to admit our collective failures in the leadership and stewardship of public funds. Mr. Murray stated there was and is confusion, inconsistent application, and conflicting interpretations. As VA's senior leaders, we have had many years to correct these deficiencies.

Mr. Murray also stated there were conflicting interpretations of the law. Here are some facts that may help you decide if conflicting interpretations exist.

In October 2012, a very senior VHA official informed me trouble was looming, as they had been violating the law on a wholesale basis with regards to the purchase of non-VA care. I asked him for details about legal documents he hinted of. He declined to reveal anything.

On October 22, 2012, I began a personal inquiry into the matter. I sent this same VHA senior official and his subordinate a written statement addressing his plight, hoping I would receive additional information from him. He declined to respond.

On December 3, 2012, I sent a note to a senior executive from the Office of General Counsel requesting a legal opinion as to whether individual authorizations for non-VA care were considered FAR-based contracts. I received no response. Receiving no response, I followed up again on December 31 and for a third time on January 15, 2013.

On February 28, 2013, nearly 3 months after I requested the initial opinion, the Office of General Counsel provided me a legal opinion dated September 10, 2009. This opinion categorically declares procurements of non-VA fee-basis care to be FAR-based. There is absolutely no confusion in this legal opinion in spite of what you've just heard to the contrary. Neither my predecessors nor myself have ever granted authority for VHA to acquire non-VA healthcare except by FAR-based methods.

You may wonder why, as VA's Senior Procurement Executive, I had never previously seen this legal opinion and why there was such obvious reluctance to provide it to me. That is an enigma.

Mr. Murray and myself testified under oath to this subcommittee in 2010, stating fee-basis care was not FAR-based. If this legal opinion existed in 2009, why was it kept from us in preparation for the hearing?

Given the apparent recalcitrance to engage by VHA and counsel, I submitted a hotline complaint to the Office of Inspector General in March 2013. The OIG initially refused my submission, questioning my motive for submitting the complaint. I stubbornly persevered, and they subsequently accepted it. I am unaware if OIG ever investigated.

In April 2013, I requested senior leadership assistance from VHA and the Office of General Counsel in conducting ratification actions for these massive violations of Federal law. I received no offer of assistance from either office.

In May 2013, Secretary Shinseki was briefed on non-VA care authority options. He was made aware of our illegal actions. I was not invited to the meeting.

In June 2013, I wrote a letter to Representative Issa, then serving as chairman of the House Oversight and Government Reform Committee, outlining my concerns in these illegal matters and oth-

ers. My letter was never—my letter never made it to him. Two senior officials, who were apparent friends, one from the House Oversight Committee and one from VHA, conspired to keep Chairman Issa and the American public from learning of these matters and other serious VA violations of Federal laws.

In April 2014, the VA Senior Assessment Team voted to close ongoing discussions of the illegal purchases of non-VA medical care with mine as the lone opposing vote.

In that same meeting, the VA Office of Management sponsored a motion, which passed, to raise the reporting level for VA material weaknesses from approximately $400 million to $1 billion. I believe this was an effort to avoid reporting emerging illegal matters to the American public through the annual statement of assurance process.

From July to November 2014, we collaboratively developed a legally sufficient method to acquire non-VA healthcare. VHA's senior leadership rejected the method in November 2014. The illegal activity continues unabated.

This past Friday, Deputy Secretary Gibson elected to make my disclosure of these and other illegal acts a personal issue with me. His demeanor and actions in both an open and one-on-one meeting were clearly meant to intimidate me and to cast a chill over me and others who might be tempted to report violations in the future.

I will allow you and the court of public opinion to decide for yourselves if what I briefly described constitutes corruption, malfeasance, or dereliction. No investigation has been conducted. No ratifications of illegal procurements have been executed. Improper payments continue. Veterans receive healthcare without protection of mandatory terms and conditions. And no one is liable.

I believe these are two relevant questions: How can we hold subordinate VA employees accountable if we, as senior leaders, selectively pick and choose the laws we want to observe for sake of convenience? When will the VA senior leaders be held accountable?

There were more than a dozen of VA's most senior leaders in the July 11, 2014, meeting. The issue of illegality was positively affirmed. Not a single leader, save one, subsequently acted in any way to protect the government's interests or resources.

We've lost our way. Senior leader is required to obey and enforce Federal laws. Our actions and inactions do not fit anything I have previously experienced in over 40 years as a military officer and civilian public servant.

Mr. Chairman, this concludes my statement. I am prepared to answer all questions the subcommittee may have for me.

[THE PREPARED STATEMENT OF JAN FRYE APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Frye.

Mr. Williamson, you are now recognized for 5 minutes.

TESTIMONY OF RANDALL WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairman Coffman, Ranking Member Kuster, and members of the subcommittee. I am pleased to be here today to discuss our work on VA's programs for delivering care through non-VA providers.

Non-VA providers treat Americans in community hospitals or doctors' offices using either a fee-for-service arrangement or a pre-arranged provider network. Non-VA providers also render care in VA facilities under a contracting arrangement or affiliation agreements with university medical schools.

In fiscal year 2013, VA spent almost $5 billion for non-VA provider medical care for more than 1 million veterans. As more veterans seek care outside the VA system, it is important to ensure that non-VA care is of the highest quality and it is reliable, accessible, and efficient.

Three recent GAO reports identified numerous weaknesses in VA's management of its non-VA medical care program, and today I will focus on issues VA needs to resolve in this area.

In May 2013, GAO reported that VA does not collect data on wait time for veterans referred to non-VA providers. Therefore, VA cannot assure that veterans are receiving access to medical care that is comparable to veterans receiving care at VAMCs.

Also, VAMCs do not have automated systems capable of collecting data for all services and charges tied to a specific episode of care during a veteran's office visit or in-patient stay. As a result, VA does not know how much it is paying for episodes of care from non-VA providers and cannot ensure that non-VA providers are appropriately billing VA for veterans' care.

In October 2013, we reported on weaknesses in VA's process for contracting with non-VA providers to provide care at VA facilities in specialties that are difficult to recruit, that supplement VA clinicians in high-volume areas, or fill critical staffing vacancies.

Specifically, we found that contracting officer representatives at VAMCs who monitor contract performance on a variety of contracts for goods and services, including clinical contracts, had heavy workloads and lacked training on how to gauge in post-award monitoring of clinical contractors, which compromised diligent oversight of non-VA providers. Robust VA oversight is essential to ensure that non-VA providers deliver high-quality care and fulfill the responsibilities of their contracts.

Finally, in March 2014, we reported serious weaknesses in the way VA was administering and overseeing its program for reimbursing non-VA providers for emergency services for non-service-connected veterans.

In processing and reimbursing claims for non-VA providers, we found patterns of VA noncompliance with its own processing requirements, attributed largely to poor oversight at both the local and national levels. Therefore, some veterans were likely billed for care that VA should have paid for, and many were not informed that VA had rejected their claims for reimbursement for care from non-VA providers. As a result, many may have been denied their appeal rights.

While VA has made progress in addressing recommendations we made on these three reports, only about one-third of them have been fully implemented.

Moving forward, as new components are added to VA's non-VA medical care program, such as patient-centered community care, referred to as PC3, and provisions of the Choice Act, it is anticipated the number of veterans seeking medical care through non-VA

providers will continue to grow. It is vital that VA establish robust oversight and accountability in its non-VA medical care program such that relevant VA staff at every level understand the importance of and are held accountable for ensuring that veterans receive high-quality, accessible, and cost-effective care from non-VA providers.

This concludes my opening remarks.

[THE PREPARED STATEMENT OF RANDALL WILLIAMSON APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Williamson.

Mr. LaBonte, first of all, thank you so much for your service to the United States Army. And you are now recognized for 5 minutes.

TESTIMONY OF CHRISTOPHER LABONTE

Mr. LABONTE. Thank you for giving me the opportunity to speak to this committee today.

I, Christopher Kevin LaBonte, had upper and lower orthognathic jaw surgery on August 16, 2013, at the Atlanta VA Medical Center. In my specific case, there have been numerous unethical and negligent issues I've had to face. I've provided a written statement which explains in detail these events and issues.

I was coerced into a highly invasive surgery, which was performed by a student with no qualifications or educational background to even be present in the room, let alone the Emory OMFS Residency program. I have submitted evidence to prove this statement in the index of evidence in my written statement.

The Atlanta VA Medical Center has also been negligent in my healthcare. They have been complicit in allowing unqualified personnel to gain entry into the VA Medical Center and also provided some of the worst healthcare I've ever experienced.

I have also submitted an index of medical evidence along with my written statement with imaging proving the willful negligence from not only the VA medical doctors but the administration and their corruption.

On the day of my surgery, the Atlanta VA Medical Center changed the consent-for-surgery paperwork to allow Ibrahim Mohamed Haron, a student from Kuwait, to be the primary surgeon performing my surgery. I have no recollection of signing this document, as medication was already administered for anxiety presurgery by the doctors.

In surgery, not only were bone shards left in my mouth, which caused further infection and bone loss months down the line, Ibrahim Mohamed Haron cut my inferior alveolar nerve. As a result of this surgery, I now have a medical condition called trigeminal neuralgia from damage to multiple branches of my trigeminal cranial nerve. Trigeminal neuralgia, also known as suicide disease, is described as one of the most painful medical conditions known to man. The VA surgical report admits to damaging a portion of this nerve, cutting it during the surgery on August 16, 2013, by Ibrahim Mohamed Haron.

According to Ibrahim Mohamed Haron's social media pages, he has devout Islamic views. I am an Army combat veteran that deployed to both Kuwait and Iraq. I was deployed to Kuwait at the

same time that Ibrahim Mohamed Haron was attending the University of Kuwait.

It is no secret that many people from this region and religion want to harm U.S. soldiers. My question to the VA is, why was Ibrahim Mohamed Haron allowed to operate on combat vets, whom he very likely would have had difficulty treating objectively or even had ill intentions towards?

The Veterans' Affairs medical centers should be sensitive to the need for veterans to feel comfortable and safe with their doctors. The VA medical centers, in fact, should be even more sensitive to this issue than any other facility in the country. As a combat veteran, I should have been given the choice to have Ibrahim Mohamed Haron involved with my care on any level, especially performing a highly dangerous surgical procedure that required me to be unconscious for an extended period of time.

I wake up every day in chronic pain due to the failed system and procedure. If you can imagine the worst tooth pain you have ever felt, that is how all the teeth on the right side of my mandible feel constantly. I have to take muscle relaxers three times a day for the facial pain—for the facial pain and muscle spasms. I take narcotic pain medications four times a day for the chronic pain, musculoskeletal pain, and nerve pain. I have to take anxiety medication to keep my facial muscles from tensing and compressing my nerves, which not only cause sharp facial pain but also cause severe migraines. These migraines feel like someone is kicking me in the skull.

I struggle with facial deformity due to the extreme cant of my lower jaw. My diet is limited to soft foods that do not require much chewing. According to my current team of non-VA doctors, I will not only need continual medical care for my mouth and jaw, but I will have to wear oral prosthetics in my mouth the rest of my life due to the surgery and also have chronic pain and require pain management for the rest of my life.

I am extremely disappointed in the VA healthcare system. The VA's priorities seem to be in the following order: one, profit; two, hospital reputation; three, protecting high-level bureaucrats; four, protecting negligent doctors; five, cutting costs at the expense of veteran healthcare; and, finally, six, veteran healthcare.

I refer to it as "death care," as health is barely taken into account. From my experience, the Atlanta VA Medical Center's motto should read, "Delay, deny, and hope you die."

[THE PREPARED STATEMENT OF CHRISTOPHER LABONTE APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. LaBonte.

The written statements of those who have just provided oral testimony will be entered into the hearing record. We will now proceed to questioning.

Mr. LaBonte, how long have you been waiting for VA and/or Emory to address the situation created by the surgery?

Mr. LABONTE. Since August 16 of 2013.

Mr. COFFMAN. Okay. So nearly 2 years.

Mr. LABONTE. Nearly 2 years. It will be 2 years this August.

Mr. COFFMAN. Okay.

Mr. Murray, in the September 2011 FHA Fee Care Program white paper, it was recommended VA conduct a cost-benefit analysis of contracting out the processing of claims, as with other payer models like TRICARE, Medicare, Medicaid, Blue Cross Blue Shield, et cetera, and their applicability for VA.

What was the result of the cost-benefit analysis?

Mr. MURRAY. Thank you for your question.

I'm not aware of that being conducted, but I believe I'll ask my VHA head of contracting activity if he's aware of that analysis.

Mr. DOYLE. Sir, I'm not aware of that analysis.

Mr. COFFMAN. Mr. Frye, any comment?

Mr. FRYE. I'm not—I'm not aware—I can't give you an answer on that.

Mr. COFFMAN. Okay.

Mr. Frye, VA Secretary McDonald was publicly critical of you after the last hearing conducted by this subcommittee on May 14, 2014. The Secretary—is this 2015?

Voice. Yes, sir.

Mr. COFFMAN. I'm sorry. May 14, 2015. The Secretary stated that he was aware of the problems and characterized your memo as, quote, "just showing what he," meaning Mr. Frye, "needs to improve," unquote. He further stated it is your, quote, "responsibility to fix it," unquote.

What is your response to Secretary McDonald's statement?

Mr. FRYE. Well, I think all of us make comments sometimes and then wish we could retract them. I'm not sure that Mr. McDonald had read my 35-page statement to him at that point. Since that time, Mr. McDonald—Secretary McDonald came to see me last week, and he expressed appreciation for me raising these issues.

In answer to your question specifically, I don't run contracting. I'm responsible for overall policy in the VA, and I have one of six heads of contracting activity who does report to me. But I do not run contracting for VA.

I think anyone who reads the document that I provided to the Secretary will see that I have struggled in trying to right the ship. And I certainly was asking for assistance from he and the Deputy Secretary, given that I have been unable to, on my own, to fix what was wrong.

So, you know, again, I make comments sometimes that I wish I could withdraw, and perhaps he does, as well. But I sincerely believe at this point that the Secretary appreciates and probably is more angry than I am at seeing this waste, given that he is trying to move us forward, and every time we move forward one step and this malfeasance is uncovered, we move backward 12.

Mr. COFFMAN. Sure. I hope you are right that he is upset.

Mr. Williamson, your testimony states VA didn't collect data on wait times from non-VA providers, leaving the Department unable to analyze such critical data, and did not provide critical oversight and monitoring of related claims or even the performance of the services provided.

GAO made 22 recommendations to address VA's shortfalls, but how is the Department—how is the Department addressing them at this time?

Mr. WILLIAMSON. On all 22? I could provide that for the record, but I will say that they have made progress.

Mr. COFFMAN. Okay.

Mr. WILLIAMSON. It's not like they're ignoring us. They are meeting with us. They're making progress.

But to consider a recommendation closed, from our perspective, requires some rigorous documentation, and VA hasn't provided that documentation as of now on many of those.

Mr. COFFMAN. Okay. Thank you, Mr. Williamson.

Ranking Member Kuster.

Ms. KUSTER. Thank you, Mr. Chairman.

I have a question at the top just to get to the bottom of the issue as to what legal authorities provide the basis for the purchase of non-VA care. And so I am asking our representatives from the VA to provide the following documents: the 2008 guidance from the Chief Acquisition Officer and Office of General Counsel that non-VA care was not governed by FAR—I think that was the original, 2008; and then the May 2013 white paper provided to Secretary Shinseki on non-VA care authority options; and then, finally—and I don't have a date for this, but I think from the testimony it is 2014—the Department of Justice ruling that referenced that VA must consider all fee-based care actions as being FAR-based.

So I want to—I am interested in going back, but I also want to try to go forward, where we go from here. I think whenever we are talking about healthcare, we are talking about sort of a triangle of access, quality, and cost. And it seems to me part of the problem that we have in terms of public policy going forward is the sheer scope of this problem. Because part of what the Choice Act entails is to bring in private-sector network coordination through TriWest and Health Net.

Essentially, that is what we are talking about here. I mean, it is massive in scope to have individual contracts. And my district is a rural district in New Hampshire. I know about these contracts. I know about these authorizations.

Could you comment—and we will start with Mr. Murray, but I would be interested, Mr. Williamson, with your knowledge of reviewing this, if you have—even if it is an opinion at this point—do you think we can get out of this morass by simply changing the rules of contracting? Or do you think that we should try to bring in the authorizations and even the FAR-based contracts into these private-sector networks?

And I will just put it—set it up to Mr. Murray, if you would.

Mr. MURRAY. So the Choice Act does have TriWest and Health Net as the two what we call third-party administrators. And, as you know, we have not got off to the start—as quick a start with those programs as we would like. Rest assured that all leadership—the Deputy, the Secretary—are doing our utmost to exercise those programs to the maximum ability, extent, to get care to those veterans that urgently need it, that have earned it, that deserve it.

The model looks like it—I go to the access meetings every morning. Many of the members of this committee have been invited to the morning access meetings. We believe it will be a very effective model for providing care in the community to our veterans.

Ms. KUSTER. Can you envision a time in the future where those networks would be sufficiently extensive where you would have dealt with the cost issue, whether it is Medicare reimbursement rates, whether you would have the quality issue addressed via the oversight by these third-party administrators? Can you envision a time where we wouldn't need to have these one-off individual contracts?

Mr. MURRAY. I will defer that question in a moment to acquisition folks and the VHA gentleman here, Norb Doyle. But, you know, it's about signing up—building the network, having those providers in the network, the right type of providers in the network in certain geographical areas of the country. We see this in the morning through our meetings with the Dep Sec and senior leadership in the Health Administration, that it is all about ensuring you have the right clinical care, right physicians, in the right parts——

Ms. KUSTER. Is there an attempt to get the physicians that you are already dealing with through these individual authorizations—is there an attempt to get those physicians into these networks?

Mr. MURRAY. Absolutely. Absolutely. So if the Health Administration leadership, if Dr. Tuchschmidt was here, he could tell you all about the options they're exercising, reaching out to their current provider network and getting them signed up or encouraging them to get signed up for Choice through TriWest or Health Net. So, you know, it's all hands on deck, everybody moving full bore to do that.

Ms. KUSTER. We will have to come back to Mr. Williamson on another round. My time is up, but thank you.

Mr. COFFMAN. Dr. Benishek, you are recognized for 5 minutes.

Mr. BENISHEK. Thank you, Mr. Coffman.

Thank you all for being here this afternoon.

I think, to me, what I have learned from this is that it is not as easy to get healthcare in the private sector for the VA as one might think. I think the TRICARE model is interesting, but, you know, they pay TRICARE the Medicare rate, and then TRICARE pays the actual providers less than the Medicare rate. In my district, nobody really wants to sign up for any of this stuff because it doesn't pay very well. And it has been, you know, problematic. Some of the Choice people offer Choice, but there's no providers that will do Choice because they are actually getting paid less than Medicare rates, because they pay TriWest Medicare rates, but TriWest doesn't pay the actual people that are providing that care of those rates. And to get those numbers, it has been tough for me to figure that out.

But my concern more is about this—for today, a little bit, is about this apparently illegal activity that has been happening. And I am just wondering—let me ask Mr. Doyle.

Are you aware that some of these things were illegal, Mr. Doyle? I mean, that is what Mr. Frye seems to—is telling us, that a lot of these purchases are illegal. And then you got a legal opinion that this is not the way it should be done, from a long time ago, which he didn't know that was the case.

You're sort of in charge of procurement of outside care, right?

Mr. DOYLE. Yes, sir. As the Chief Procurement and Logistics Officer for VHA, I do do—we do contracts for non-VA care——

Mr. BENISHEK. So is your opinion different than that of Mr. Frye, that this is not illegal? Is that what is going on?

Mr. DOYLE. No, sir. I'm not a lawyer, so I'm not a judge, but I refer to my legal counsel, and I don't believe they would say it's illegal what we're doing. (I don't recall using the word delinquent).

Mr. BENISHEK. So there's a difference between what you believe and what Mr. Frye believes.

Is that right, Mr. Frye? Is there a basic difference here, or am I talking about two different things? It is a little bit confusing to me.

Mr. FRYE. Yes. I think what counsel will tell you is these aren't illegal; they're improper. Now, it's illegal to go through a stop sign in my neighborhood, but it's improper to spend billions of dollars outside the law in the VA. It makes no sense.

This is the same argument that counsel—the same specious argument that counsel used several years ago when there was an argument in these chambers about the buying of pharmaceuticals without contracts. And, at that time, the Deputy Secretary was here at the table, and he in his oral statement was about to make the statement that it was improper and not illegal, and this body absolutely confirmed that it was illegal.

If we are going to a court of law, the Supreme Court, I'd love to have the argument made that these are improper not illegal. But this is the court of public opinion—the court of public opinion, not a court of law. These are——

Mr. BENISHEK. Let me—isn't fee for service providing—different than contract? I mean, I am a private physician, and I worked at the VA for 20 years. And I was a fee-for-service physician, so I didn't have a contract. I agreed to a fee.

And, frankly, I wanted to do a contract, but it was so difficult to get the contract, it would take months or more than a year to get the contract negotiated and completed, so that they couldn't get it done. So they actually preferred to do it fee-for-service because they could get that done right away. And, you know, I don't know what exactly the details were, but——

Mr. FRYE. I'm sorry to hear that you weren't on contract. It sounds like an unauthorized commitment. I'm not familiar with the—with the methodology that they used to bring you on, but if we're required to have a contract, we're required to have a contract.

Mr. BENISHEK. All right.

Well, let me go to a different thing. Mr. LaBonte, let me ask you a question about your care. You say that you don't think you signed a consent form before you had narcotics or some sedative——

Mr. LABONTE. Oh, I signed a consent form after I was administered an anesthetic to calm me down before the surgery. I had to sign a digital pad. I wouldn't really call it a consent form, considering I never saw any paperwork. I don't recall signing it, but apparently I scribbled on a digital pad, under the anesthesia, to give the resident, Ibrahim Haron, the primary surgeon slot during my surgery instead of Martin B. Steed, the surgeon that was supposed to be conducting the surgery. To me, that sounds illegal, but I'm not a lawyer.

Mr. BENISHEK. Well, it's highly unusual, in my experience, that anyone—I mean, nobody—where I come from, nobody's allowed to

sign a consent after they had any drugs. So I'm just—you know, that's usually witnessed by somebody.

I imagine you have all these documents. Is there—are you doing a lawsuit in reference to all this stuff?

Mr. LABONTE. There's a court claim pending.

What's also unusual is that Ibrahim Haron is the only—is the only resident in the entire OMFS program that has a bachelor's degree instead of a doctorate. So I find that unusual too. There's lots of things that are unusual about the Atlanta VA Medical Center. So——

Mr. BENISHEK. Well, I think maybe that needs a little more work than we've seen here today, Mr. Chairman.

I'm out of time. Thank you.

Mr. COFFMAN. Thank you, Dr. Benishek.

Mr. O'Rourke, you are now recognized for 5 minutes.

Mr. O'ROURKE. Thank you. Thank you, Mr. Chairman.

Ms. Anderson, I will ask you—because Mr. Frye earlier summarized what he thought your response would be to the question—was this or was this not legal?

Ms. ANDERSON. And not to put too fine a point, this—these were not illegal actions or illegal activities. Yes, they were not FAR-compliant. An illegal contract—and I'm speaking as a lawyer—an illegal action or an illegal activity, it's not enforceable. These commitments are enforceable.

In fact, the Federal Acquisition Regulations acknowledge, understand that there are times when officials not authorized to commit the government, they do commit the government. And there is a formal ratification process.

The courts and the boards have recognized that when the government makes a commitment, pays, receives the services, that the government can't hide behind the fact that you didn't follow the FAR. The government received the benefit. And there is a legal theory for recovery on that.

So I respectfully disagree with Mr. Frye's position that these are illegal contracts.

Mr. O'Rourke. It sounds like—I may or may not be following the distinction. It sounds like this is a obligation by which the VA is legally bound to fulfill.

Did someone at the VA do anything illegal in committing the VA to this obligation?

Ms. ANDERSON. If we're addressing merely the fact that a person not committing—not authorized to perform—enter into a contract, the answer is there was no illegal activity.

Mr. O'Rourke. Okay.

And then, so, for Mr. Murray, then, to follow up, if this was not illegal, was this improper?

Mr. MURRAY. Thank you for your question.

"Proper" is an interesting question, because if you establish the obligation, the provider provided the service, the provider billed correctly, and the provider was paid, one would argue that it was proper but not FAR-compliant.

Mr. O'Rourke. Should the obligation have been entered into in the first place? Was that proper?

Mr. MURRAY. It—so thank you again for your question.

So was it proper? If it was—so, "proper." I'm struggling with the word "proper."

Ms. ANDERSON. May I——

Mr. MURRAY. Yes.

Ms. ANDERSON. I'd like to address that. And this is going afield on the appropriations—the appropriation area.

So that just—if funds are available, one, we have the authority to contract. Done improperly, but we do have the authority to contract for these services. If funds are available, then they're proper. The payments are proper, from an appropriations and authorities——

Mr. O'ROURKE. So let me ask this followup question, Mr. Murray. Have these actions, these obligations been ratified? In other words, has this been blessed by the VA?

I am just trying—so I think we are all concerned about what has happened here, and I think we just want to know the basic question of whether you are concerned and you think this was appropriate or not.

Mr. MURRAY. So, as we know, the Office of Inspector General recently reviewed unauthorized commitments in the purchase card program. For those that were identified by the OIG, we did 100 percent of review of that entire sample, and we referred those to the head of contracting activity for a ratification review and ratification if appropriate. So that's where those are.

Now, those were with respect to purchase card transactions above the micro purchase threshold. So if they were identified as being—we didn't have the authority under the VA acquisition regulations—which said you can go to 10K, right? Mr. Frye will tell you about that. If they were above the $10,000 authorization for fee care and they were non-FAR-based, one could logically say that they probably require ratification. And if they require ratification, one could make an argument that they perhaps were not proper.

Mr. O'ROURKE. Okay. I will allow a colleague to pursue this because I—if they choose, because I am out of time.

And, for the record, I will ask Mr. Williamson what is knowable about the cost of purchasing this care without contract. Seven billion dollars, do we know it, or is it knowable. But I realize I don't have time now, so we will ask this question for the record.

And I yield back to the chair.

Mr. COFFMAN. Thank you Mr. O'Rourke.

Mrs. Walorski, now 5 minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

I am aiming this in the direction of Mr. Murray and Mr. Doyle, I am not sure which. But there is a business in my district that supplies specialized shoes, diabetic shoes, and custom inserts to vets through the VA. However, this business didn't have a contract.

In November of 2014, VISN 11 notified them that the custom orthotic appliance and related service released a request for proposals. The business filled out all the paperwork. They were denied for not meeting the minimum technical requirement of having a certified, not podiatrist, but pedorthist on staff.

My question is, who sets the technical requirements for these contracts, the VISN or the main VA office?

And then my second question is, since this business did not have a contract, how do you think the VA was paying them for the services they provided?

It doesn't matter——

Mr. DOYLE. I'll take that.

Mrs. WALORSKI. Okay.

Mr. DOYLE. One, I'll need to explore more the specifics in this case. But the requirements, if it was done by VISN 11, it was probably done by the local contracting office that supports VISN 11, and they work for me in my organization. They probably worked very closely with the prosthetic folks in that VISN or at that medical center to develop the requirements. It is not set by the central office, I don't believe, in this particular case.

Now, I don't know about the contract situation or not, but it is possible that they were being bought under the micro purchase threshold of $3,000 by the local prosthetics folks with the government purchase card.

Mrs. WALORSKI. Well, and I guess, you know, my followup question to that is the owner did say they would receive a purchase order that would have a credit card number on it and an expiration date. They could purchase—they couldn't purchase more than one set of shoes, though, or inserts per time.

And my question is, when you're talking about—this particular organization serviced about 200 veterans in my district, and now they can no longer do that. There really is no competitor. And, you know, when businesses that are highly specialized that service veterans get stuck in this cycle in the VA between—they don't know—they are not setting the rules. They are responding to an organization saying, you know, yes, we will join with you in partnership to provide some kind of specialized care.

Mr. DOYLE. Yes.

Mrs. WALORSKI. And so, you know, it is harmful to the folks on the other end of this trying to comply, getting an RFP in the mail saying, you know, now you have to sign up for this. They had been providing this for a couple years already, and then they get thrown out because they didn't have a minimum certification. But it was okay and it was fine as long as they were being paid through the credit card number and the purchase order.

It just—don't you see an inequity in that, when you are trying to keep service providers even available? They have no idea what you guys are doing and what is complicit and not complicit.

Mr. DOYLE. Right. I understand. I would say this sounds like, if they were doing repetitive orders with a government purchase card, one could make a logical argument that that is a split requirement. If it's a split requirement that goes above the micro purchase threshold of $3,000 in this case, there should be a FAR-based contract in place.

Mrs. WALORSKI. And you can check this out for me if I give you the info, the personal info on it——

Mr. DOYLE. Yes, I'm happy to do so.

Mrs. WALORSKI. Okay. I appreciate it.

I yield back, Mr. Chairman. Thanks.

Mr. COFFMAN. Thank you, Mrs. Walorski.

Ms RICE. you are recognized for 5 minutes.

MS RICE. Thank you, Mr. Chairman.

I feel like I missed something here. I'm just trying to figure out why—and maybe, Mr. Murray, you can answer this question. Why is there such a reluctance to apply FAR regulations when you are talking about non-VA care? If you can give that answer succinctly, because I have a lot of other questions.

Mr. MURRAY. I don't sense there's a reluctance at, you know, the leadership levels. In fact, all the leadership levels I see, you know, PC3, Choice, provider agreements, seem to be the preferred approach for providing care in the community. And if you want to delve into this, I think that Chief Acquisition Officer, the head of contracting activity for the Health Administration, might have some sense for why this is true or could be true in the field.

Mr. GIDDENS. Ma'am, one of the things that we tried to address—and we tried to do it with the legislation request that came in—was to recognize that there are some vendors that may shy away from doing business with the government. We're not known as being the most streamlined and the most easiest to deal with. Vendors have to get Dun & Bradstreet numbers. They have to apply for Federal contract wage statutes. There's a lot of additional activity they do to do business with the government.

And what we tried to recognize with the legislation is there's an order of precedence. We want to start and deliver and provide care in our VA medical centers. Next is with contracts; next with agreements. Our last preference would be what has been termed the individual authorizations.

So we want to have that as really kind of the backstop that, as we go through this priority, this hierarchy of providing care, we see that as the least preferred option but one that we don't want to take away from approximately 400,000 veterans that are being served by some of those small providers——

Ms RICE. But it's become a $7 billion backstop, right?

Mr. GIDDENS. I don't know all seven of that—all seven, I believe, is for overall fee, and some of that is happening through FAR and non-FAR. I don't have the breakout.

Ms RICE. Well, the problem is that there is no comprehensive auditing that has been done.

I guess, Mr. Williamson, if you could—I mean, what I see a pattern of is either GAO or the inspector general saying, here's a problem, here is how you fix it, and an intentional or negligent failure on the part of the VA to take recommendations and actually implement them.

So can you just tell us what you recommended the VA do and where they are still lacking?

Mr. WILLIAMSON. Well, of course, as you know, we put VA on our high-risk list very recently, and part of the justification for that was that they are not implementing many of the recommendations. In fact, there were over 100 recommendations we've made that VA has not implemented just in the healthcare area alone.

So there are 22 recommendations from 3 reports on Non-VA provider care. I don't want to use all your time up, but let me give you a couple examples. One is that we recommended that VA keep track of wait times for veterans that went to non-VA providers.

They have not yet done that. We have talked to them about it. They still haven't done that.

Ms RICE. What is the reason for them not having done it?

Mr. WILLIAMSON. We don't really know.

Ms RICE. Well, when you ask them, you tell them how to do it——

Mr. WILLIAMSON. I think what they're looking at—VA wants to close a case from the time the veteran starts the process of getting an appointment until the time the claim is paid. They want to do that in 90 days. And VA is tracking that, but for some reason they're reluctant to track the 30 days.

Ms RICE. Why?

Mr. WILLIAMSON. Good question. I don't know that they've given us a great answer on that.

Ms RICE. What would be a good answer? Is there a good answer?

Mr. WILLIAMSON. They probably don't have the systems to do it. It takes a lot of work. It requires having some good data. But that's not a good reason, necessarily, for not doing it.

Ms RICE. Mr. Williamson, so you have laid out a blueprint for how the VA can improve, whether it is tracking wait times, doing better audits to see where these multi-billion-dollar expenditures are going. And I guess maybe there isn't an answer to this.

But it seems to me that you have not been able to get any satisfactory answers as to why your recommendations have not been implemented. And maybe you are not the right person to answer this, but I don't know if anyone at the VA—I haven't heard Mr. Murray give any explanation as to why.

Mr. WILLIAMSON. Well, I think part of it always comes back to the same issues, no matter what program you're reviewing in VA. The data is often insufficient. The automated systems they have, in many cases, cannot produce the kinds of things they need. And it comes down to a lack of oversight both at the local level and at the headquarters level. It happens time and time again; the claims-processing problems we found on the emergency care for non-service-connected veterans, is a good example.

Ms RICE. The problem is that there will be no overall cultural shift at the VA unless there is meaningful oversight, whether you are talking about this issue or you are talking about how whistleblowers are treated or anything else.

And that is really part of the problem, isn't it?

Mr. WILLIAMSON. It comes down to accountability, and it's not there.

Ms RICE. Thank you, Mr. Williamson.

I yield back, Mr. Chair.

Mr. COFFMAN. Thank you, Ms. Rice.

Mr. Lamborn, you are recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

And I appreciate your leadership in pursuing yet another scandal, basically. Here it is June 1. It is another month, and we have got another scandal. And it seems like the whole year has been like this, and I, for one, am getting sick and tired of it.

Mr. Williamson, I would like to ask you for some background in this whole issue. Whether we call the contracts illegal or just improper or noncompliant, what can go wrong when the VA doesn't

follow the proper procedures as regards these contracts? Mr. Williamson.

Mr. WILLIAMSON. You're talking to me?

Mr. LAMBORN. Yes.

Mr. WILLIAMSON. Oh, okay. I thought you were saying Mr. Giddens.

Mr. LAMBORN. But from a GAO perspective.

Mr. WILLIAMSON. You know, I'm not a lawyer or a procurement expert either. And in listening to what I've heard today from the VA witnesses, I'm a bit confused because, on one hand VA says there's no impetus or there's no reluctance to go to a FAR-based kind of process for purchased care for VA non-providers, and I think there obviously is or, otherwise, Mr. Frye would not have had the difficulty he's had.

I think I would want a FAR-based system would impact the access for veterans because the end game here is still providing high-quality, accessible, and cost-effective care for veterans.

And so, if a remedy to solve the problem is a FAR-based—if it's determined that a FAR-based system should be used here I would want to know how long would it take in this process for a contract to be executed and what the process means. I would want to know how it would affect the accessibility to care for veterans.

Also, one thing we haven't mentioned yet is the whole idea of what it would mean for VA's acquisition workforce. When we did our clinical contract care work, we found that the contracting officers and the contracting officer representatives who do most of the legwork for the contracting officers are already stressed in terms of workload.

If you increase that workload, you double it, tenfold, whatever it would mean to get a FAR-based system implemented, then— what would it mean in terms of VA's budget for hiring new people?

I just don't know what a FAR-based system would mean in terms veterans' of accessibility to care and VA's acquisition workforce, and that's what we need to know.

Mr. LAMBORN. Well, it is interesting that GAO has identified six categories of problems that can arise when proper oversight is not provided by the VA: the type of provider care, credentialing and privileging, clinical practice standards, medical record documentation, business processes, and maybe the most important, to me, access to care.

So let me turn now to Mr. Frye. Would you agree that those six areas are called into question when proper procedures are not followed?

Mr. FRYE. Well, yes. Absolutely.

And, in addition to that, when Federal contracts are required and you don't use them, there are terms and conditions that are completely missing from the contract. By Federal statute, you're required to have terms and conditions.

These include the termination for convenience, termination for default, the disputes clause, fair and reasonable price determination, just a whole host of issues not—and probably even more important in terms of healthcare, the safety and efficacy terms and conditions that are required to be followed by the specific contrac-

tors. Without a contract, without those terms and conditions, the contractor is free to do what he or she wants.

Mr. LAMBORN. Well, and that is my concern.

And, Ms. Anderson, in regards to your statement earlier, I have to agree with you. The government is obligated to pay for services that are rendered, even if the proper foundation wasn't followed—you know, the procedures weren't followed in soliciting those services.

Ms. ANDERSON. Thank you for the opportunity to respond to that.

We were comparing a FAR-based contract and what it will take to become FAR-compliant and then, to Mr. Williamson's point, to what end. Will that result in immediate care to the veteran?

And I chaired a work group in July of 2014, and that work group was responsible, tasked, with identifying measures in how do we become FAR-compliant.

We realized after 3-hour weekly sessions over 4 months that there are lots of hurdles to overcome, not the least of which, labor issues, consultation with labor, hiring a contracting officer workforce, estimate 600. Then it's how immediate can we really give the care at that point. Still, we need to go through the hurdles.

So we quickly realized that we need to really begin aggressively pursuing legislation. And in aggressively pursuing legislation, working with the Department of Labor, working with OMB, working with the Department of Justice, we've embedded in the legislation protections, credentialing, quality of care——

Mr. LAMBORN. Ma'am, maybe you are getting into another issue that is a very important issue, the proposed legislation. My time is way over. I just wanted to make the point.

No one is arguing that the government should not pay these contracts. I am concerned about what GAO and Mr. Frye have identified as what can go wrong when the procedure is not followed.

Mr. Chairman, thank you for your indulgence. I yield back.

Mr. COFFMAN. Thank you, Mr. Lamborn.

Mr. Walz, you are now recognized for 5 minutes.

Mr. WALZ. Thank you, Mr. Chairman.

And, first of all, Mr. LaBonte, my deepest apologies for you. And what I understand and you understand much more clearly is that veterans' care is a zero-sum proposition. If one veteran doesn't receive the care that they are entitled to and the best quality, then it is a failure. So your situation is unacceptable.

The thing I would encourage you on is—and I looked into this—the tort issue. That is your recourse on this. And they will always try and throw barriers up both in the private sector and in the public. But there are a lot of good folks out there that can help with that. So I would hope you would pursue that.

Mr. LABONTE. Well, the efficacy of the tort program is that the VA essentially investigates themselves. I mean, their attorney acts as an investigator, which is——

Mr. WALZ. Well, trust me. People win these. And what I am saying is, if this was wrong, there are people out there to assist you. There are veteran attorneys that are veterans themselves that their job is to try and help make this right.

Mr. LABONTE. Yes. But the VA has a 6-month head start to coach witnesses, "Well, you're not allowed to file a Federal lawsuit."

Mr. WALZ. Yes. And I agree. And it is never easy. I think, as you are sitting here listening to this, the issue for you is that all the rest of this is kind of irrelevant.

Mr. LABONTE. Yes.

Mr. WALZ. The issue is what happened to you.

Mr. LABONTE. Yes.

Mr. WALZ. And I would just say, from your perspective, there are two things happening here. We are kind of at the 40,000-foot reform discussion here. My advice to you is that go down that road, pursue that hard, and that is where you can get—redress your——

Mr. LABONTE. That's what I'm doing now. And I'm witnessing that that program is ineffective as far as VA investigating themselves.

The VA attorney sends the information that I send the attorney/investigator to the actual hospital risk management coordinator, who then tells the privacy officer which records they need to keep or manipulate or lose and then tells the Department head how to coach their residents specifically to the legal matter.

So I would say that that recourse is ineffective and it's designed to protect the hospital's reputation rather than actually help the veteran——

Mr. WALZ. I wouldn't disagree with you. There is folks out there to advocate for you—stick with it—veterans' service organizations, others. So stick with it.

Mr. LABONTE. Thank you.

Mr. WALZ. I am going to move back to, again, our 40,000-foot—and I appreciate you all being here.

And my colleague from New York, Ms. Rice, was hitting on this, Mr. Williamson. I have seen this before. GAO puts out 22 recommendations.

What exactly is the weight of a GAO recommendation? Exactly what does that do?

Mr. WILLIAMSON. We report to the Congress and the Congress provides the leverage we need, and it's forums like this that we use bring those things to light.

Mr. WALZ. Exactly.

And this is why—and, again, Mr. Murray, I could go down here and ask why some of these, but I do think—and I don't think it was necessarily even a rhetorical question. I do think you are the wrong person to answer this because what we are in is—and this needs to be fixed and somebody needs to deal with this.

But this is a much broader issue. This is the reform issue. This goes back to the VA being all things for all people. And not to antagonize my chairman, but this is the VA trying to build hospitals. This is the VA trying to do everything for everybody.

And I have been saying we need to have that discussion to figure out how do we best leverage both the private sector, the public sector, our promises to our veterans, get quality care, and do it in the most cost-effective manner.

So we are here, I would argue, dealing with a very important issue. And it is very granular, and we are discussing inappropriate versus illegal. And they do matter.

The bigger issue here is that, if I would ask the questions—and, again, I don't think they are fair to you, Mr. Murray—what should be the VA be doing, how do we fix this contracting, what is the purpose of this, and we will get back into Mr. Frye pointing out where those holes are in there, this is probably not the forum for that.

So I appreciate you all being here. I don't question that we are all trying to get to the same point. But you heard Mr. LaBonte. This is what happens when you break faith. He doesn't believe that anybody is going to get good care. And we can tell him countless stories of the highest quality healthcare delivered in the country by a VA hospital, and it would be irrelevant to him.

And I think that is a noble goal for us to continue to strive for, but I don't think we are going to get there in the current system. I am quite confident your 22 recommendations will be recommended in 2 years from now and we will still be trying to implement them, and that is a horrible condemnation on the entire process.

Mr. WILLIAMSON. They have implemented seven of them.

Mr. WALZ. Yeah. Well, and it is. And, again, it is not because the motive is to not provide quality care. I think it goes back to the institutional design and some of the issues on culture that we are trying to get to. And I think that level over the top of this is going to make answering many of these questions very difficult.

So I thank you, Chairman, for your time.

Mr. COFFMAN. Well, again, Mr. LaBonte, I certainly apologize for your situation, and I think you personalize the problems in this contracting process.

I am stunned by the kind of bureaucratic incompetence, the corruption, the lack of leadership demonstrated here today where what I have heard is, "Yeah. We have these rules, but they are really not important." The kind of lawlessness that exists in this Department is just extraordinary.

Mr. Frye, what you heard here today was essentially, splitting hairs, "Oh, it is really kind of not improper," "Oh, it is really not illegal, but we don't follow the law here because we are somehow above the law."

I mean, Mr. Frye, could you comment on what you have heard today.

Mr. FRYE. That's exactly right. Let's talk about those purchases above $10,000. They are using the same methodology that is used from $1 to $10,000 above $10,000. That authority has never existed.

Every purchase, every acquisition in healthcare above $10,000, must have a FAR-based contract in place. It must be signed by a duly appointed contracting officer. And I will take issue with Ms. Anderson. We can't pay that unless it's been ratified by a contracting officer.

A ratification is a requirement where a contracting officer must do an investigation. We can't liquidate that obligation willy-nilly, but we are. We're going ahead without doing ratifications and liquidating the obligation.

Those are improper payments, by the way. Our own regulations in the GAO Red Book and other statutes state that we will not pay unauthorized commitments until they are ratified. We've done it wholesale.

To my knowledge, not a single one of these requirements above $10,000 has ever been ratified, and we bought billions of dollars' worth of healthcare. If that isn't illegal, I don't know what is. But I guess we can—we can parse words here.

Mr. COFFMAN. Mr. Frye, is there anybody else in senior leadership, besides yourself, that actually cares about getting this right?

Mr. FRYE. It doesn't appear that there's anyone outside my organization that cares. I come to work every day, and I watch this malfeasance. I watch this malpractice. You know, they've made a mockery of the Federal acquisition system.

The FAR has the same force and effect as the law. We all know that, those of us who were trained in its use, and certainly the attorneys know that. And we're just ignoring it.

This isn't done in any other government agency. If you were to bring other government agencies, senior procurement executives or chief acquisition officers, you wouldn't get this same story. This is just another example of us trying to blow smoke up your sleeve.

Mr. COFFMAN. Is Secretary McDonald just a placeholder? I don't sense that he is working to make a difference here. Does he care?

Mr. FRYE. I hope Secretary McDonald cares. Again, I think Secretary McDonald dislikes these scandals, this malfeasance, more than anybody else because he's got a very short window here to move the VA forward. And, again, he moves us 2 steps forward and we move 12 steps backwards every time one of these scandals arises.

Mr. COFFMAN. Thank you.

Ranking Member Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you.

Mr. Frye, let me just follow up on this. If every single one of these contracts was FAR-qualified or whatever the verb would be, what would the time commitment and cost to the VA be for that process?

Mr. FRYE. Thank you for asking that question.

So from $1 to $10,000, we have a non-FAR-compliant—however, it is FAR-based—system in place. It's like falling off a rock. It's non-FAR-compliant. The appropriate terms and conditions are in that contract.

It is simply a process where authorized personnel, not contracting officers, sign this document, and they are on their way to the doctors. It's not hard at all. And it's been this way for years.

Now, we all recognize, including counsel, that it is not compliant with the FAR. And so a year ago in July, we began a 4-month effort to bring it in compliance.

But in November, after all that effort, Veterans Health Administration summarily rejected it. It didn't go far enough for them, even though it was FAR-compliant. So——

Ms. KUSTER. But that is my concern, is that—we have heard from my colleague, Ms. Walorski, that a company that had been providing services was—obviously, somebody draw attention to that. They didn't have a contract. They tried to go through a con-

tract. But, in fact, the process was so burdensome, what ended up happening was that the veterans didn't get the podiatry that they needed because that company was disqualified. There was no other company available.

So I want to try to understand how do we get from here—I recognize the problem. I agree with you we have got a problem. How do we get from here to veterans all across the country getting timely care in a cost-efficient, high-quality manner?

Mr. FRYE. Sure. And I realize there are issues sometimes with veterans getting care no matter what system we have, whether it's in the VA hospital——

Ms. KUSTER. But would you agree that there is an added cost for all this administrative procedure on top? I mean, I am not—I am not condoning it.

I am just asking you——

Mr. FRYE. I have no idea if there's an added cost. But I will tell you this.

Ms. KUSTER. Well, we talked about——

Mr. FRYE. There is a requirement.

Ms. KUSTER. We talked about 600 additional people.

Mr. FRYE. There is a requirement under the Federal acquisition regulation to do it. I don't make the laws, but I——

Ms. KUSTER. I understand the requirement.

Mr. FRYE. I comply with the laws.

Ms. KUSTER. I am not asking you about the requirement. That is up to us.

Mr. FRYE. Right.

Ms. KUSTER. What I am asking you is: What is the cost to the system for each one of these authorizations to be compliant?

Mr. FRYE. You're asking the wrong person. You'd have to ask the program officials.

Ms. KUSTER. Do you agree that there is——

Mr. FRYE. They're the ones that make the business decision.

Ms. KUSTER.—a cost, that there is potential delay, there is an administrative procedure that has to go on, there are individuals that have to be involved? Do you agree that there——

Mr. FRYE. I agree——

Ms. KUSTER [continuing]. Is a cost?

Mr. FRYE.—there is a cost of doing business using any system, whether it's the Federal acquisition regulation or any other system. By the way, I am ambivalent. If the Federal acquisition regulation wasn't used, that's fine.

But we have to have a system. We can't just spend money like drunken sailors willy-nilly. If we're going to have a non-FAR system, then let's put a non-FAR system in place. Let's go through the rulemaking process at OMB. Let's then promulgate those rules. And then let's comply with the rules. It's as simple as that.

Ms. KUSTER. What do you think is the correct dollar amount that we would have the balance of being able to supervise contracts, but not have every last paper clip be covered by this contractual obligation?

Mr. FRYE. Again, I have no idea. I'm not the program official. But I can tell you this. We have FAR-based contracts in place.

PC3, which you may be familiar with, is a FAR-based contract. It provides specialty care, and it goes up into the hundreds of thousands of dollars. And veterans are getting care every day using PC3.

Ms. KUSTER. And do all the providers in the PC3 network have a FAR-based contract?

Mr. FRYE. Have a what contract?

Ms. KUSTER. A FAR-approved contract——

Mr. FRYE. If they're in the——

Ms. KUSTER [continuing]. Even in a rural area like I am in, individual provider?

Mr. FRYE. No. There are some rural areas—for instance, there's another FAR-based contract, which you're familiar with, called ARCH. I am not that familiar with it because I am not a program official, but I know it exists because of care that's required out in rural areas.

Ms. KUSTER. Well, my time is nearly up.

But I think what I am interested in, going forward, is let's separate out the ones that are possible. I would like to hear more about the PC3 FAR-based contracts and then not chase every last one down a rabbit hole with 600 new employees. But let's try to use a public-private arrangement.

Because I know it is expensive. I have been in healthcare for the past 25 years. It is expensive to supervise these contracts, and we are going to have to get to the bottom of it. So thank you.

Mr. COFFMAN. Mr. Lamborn, you are now recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Mr. Murray, I have got a question or two for you. I want to ask you about the proposed legislation that the VA has come up with—and I think Ms. Anderson made reference to it—basically, to let VA off the hook and say, "You don't have to follow FAR anymore for these kinds of contracts."

And that really bothers me because one of the potential abuses that can happen when FAR or something the equivalent of FAR is not followed is that there is the potential for cronyism or higher prices. It is sort of like sole-sourcing of contracts and the taxpayer isn't given the benefit of competing bids and that kind of thing.

So would you agree with me that the legislation—or I won't put it that way. Are you concerned that the legislation VA is proposing could allow for those problems to arise?

Mr. MURRAY. I am. And I'm concerned about that sort of thing, fraud, cronyism, paying more than you should across programs, whether it's travel or conference spending or whether it's payroll, get a major initiative to make sure, you know, payroll is where it needs to be in terms of controls.

So, absolutely, which is why it's so important that controls that we suggested—and perhaps more are required in these—in this legislation—be implemented. You know, reviews.

The control that I am intrigued with is that we review these individual authorizations to see if they pass the threshold, a million dollars annually, and, if so, we start thinking right away maybe this needs to be FAR-based. We're doing a lot of this, for instance.

Mr. LAMBORN. Well, but the specific language that concerns me in the proposed bill says, quote, "that healthcare can be awarded," quote, "without regard to any law that would otherwise require the use of competitive procedures for furnishing of care and services," unquote. So, to me, that opens the door for potential cronyism.

Mr. Frye, would you like to comment on that same question?

Mr. FRYE. Well, that piece disturbs me as well. But I think, in the background, there may be some additional information. Counsel, down at the end of the table, was involved in putting that together.

But, certainly, again, if you give us legislation that allows us to do something besides the FAR, I am ambivalent, but we have got to develop those rules, go through the rulemaking process, put those rules in place, and then we have to enforce the rules and hold people accountable.

We don't hold people accountable for anything right now. Yet, you know, we come down here. I read the newspapers every day. Chairman Miller says, you know, why aren't things working, why don't we follow the rules?

It's because no one is held accountable. No one. No one has been held accountable at all for these violations of Federal regulations in law in the course of events with these obligations for fee basis care, and I suspect no one will ever be held accountable.

There are hundreds of thousands of these transactions that should have been ratified. There are billions of dollars that have been spent, and we'll just sweep it under the carpet.

Mr. LAMBORN. Well, I am truly concerned about that.

Mr. Chairman, I appreciate your leadership on this issue. And I yield back.

Mr. COFFMAN. Thank you, Mr. Lamborn.

Mr. O'Rourke, you are recognized for 5 minutes.

Mr. O'ROURKE. Passes.

Ms RICE. you are recognized for 5 minutes.

Ms RICE. Thank you, Mr. Chairman.

Mr. Williamson, I just want to follow up on Ms. Kuster's line of questioning in terms of the VA's position that was stated previously, that following FAR would impact a large number of veterans by compromising immediate access to care in our community providers.

Now, forgive me if this was already spoken about. But do you share that?

Mr. WILLIAMSON. I share your view; it's very much of a concern. Again, unless I know more about how a FAR-based system would work for purchased care for non-VA providers and I know how long it would take to execute these contracts, I can't give you an answer.

If I had that, I would. But my concern is that it's going to take a longer period of time for the process. In the meantime, the access to care that veterans have to non-VA providers may be degraded.

Ms RICE. So we have to figure out a way to either not have FAR apply, right, and implement your recommendations?

Mr. WILLIAMSON. But what is our recommendation on that particular aspect? I am listening to all of the dialogue here, and I think that whatever is decided upon we have to know some facts first about how such a system would work.

Ms RICE. Where can you get those facts from?

Mr. WILLIAMSON. Please repeat.

Ms RICE. Where can you get those facts from?

Mr. WILLIAMSON. Well, first of all, for the care that's given—and, by the way, if 80 percent of the veterans used the PC3 network of providers, it would solve a lot of the FAR-based issues. But they don't. A very minute number of veterans currently use PC3 providers for a lot of reasons.

In any case——

Ms RICE. You think that is the answer—that could be one of the answers here?

Mr. WILLIAMSON. Well, it's one of the answers. Certainly it is. But for every other form of non-VA provider care there is, this issue of what's FAR-based and whether it's being done illegally or not.

Questions need to be answered such that there is clarity not only on the accessible care issue, but also on the cost, because I think that the impact on the acquisition workforce in VA would be potentially quite a bit in terms of having to hire more people. But you have got to get those answers first, and I haven't heard it here.

Ms RICE. Well, that is the problem at these hearings. A lot of questions are asked and very few answers actually are received. Thank you.

I yield back, Mr. Chairman.

Mr. GIDDENS. Ma'am, could I follow on to your question, please?

Ms RICE. Mr. Chairman.

Mr. COFFMAN. Go ahead.

Ms RICE. Sure.

Mr. GIDDENS. So I find myself in complete agreement with Mr. Williamson, that we have to balance this need for access and provide the right structure that represents the interest of the taxpayers so it's balancing what's good for veterans and what's good for taxpayers.

And the answer to his question about how we look at that and how we balance that is I own that for the Department. I am going to work to put that together. I would love to meet with the committee and/or the staff as we do this and get your input.

But I have to find a way that allows us to balance this, to meet the needs of the veterans, to manage their access, while at the same time representing the interests of the taxpayer and recognizing the Federal acquisition regulations and all the appropriate laws. I own that for the Department.

Ms RICE. Well, thank you for that offer.

Mr. COFFMAN. Well, I would like to thank the witnesses. You are now excused.

And let me just say it really doesn't matter how the system's changed because, if you are not going to follow whatever system is there, because if you don't have the discipline, you don't have the leadership, it really just doesn't matter.

I mean, at the end of the day, there has got to be a rule of law. And this is just—I think some of the witnesses today just, you know, really demonstrated how lawless this organization is. You are now excused.

Today we have had a chance to hear about problems that exist within the Department of Veterans Affairs with regard to oversight of its non-VA healthcare programs.

This hearing was necessary to accomplish a number of items: number one, to identify the continuing widespread problems with procurement of non-VA healthcare; two, to allow VA to provide answers as to why these problems still exist and have been allowed to continue for so long; and, three, to assess next steps that must be taken by the Department in order to stem the continued waste of taxpayer dollars and jeopardized services provided to veterans.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous materials. Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining us at today's conversation.

With that, this hearing is now adjourned.

[Whereupon, at 5:30 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN MIKE COFFMAN

Good afternoon. This hearing will come to order.

I want to welcome everyone to today's hearing titled, "Circumvention of Contracts in the Provision of Non-VA Healthcare." This hearing is the second in a series of hearings examining illegal VA procurement practices resulting in massive waste of limited taxpayer resources and serious jeopardy to the quality of healthcare received by our Nation's veterans.

In our previous hearing on procurement, on May 14, 2015, we focused on the mismanagement and misuse of purchase cards in avoidance of contract requirements, spending limitations, and warrant authority. VA's Senior Procurement Executive, Mr. Jan Frye, testified that these unauthorized commitments were in the billions of dollars. Mr. Frye has indicated similar levels of mismanagement and abuse in the procurement of non-VA healthcare services by VHA.

By far, the most prevalent method by which veterans receive non-VA care is through the individual authorization, so-called fee basis, process. Under title 38 of the Code of Federal Regulations, section 17.52, VA is authorized to obtain non-VA medical services when demand is infrequent and the needed healthcare is not available in-house or through an existing contract. Unfortunately, VA uses this process even when these requirements are not at issue. Moreover, VA admits that the execution of these authorizations does not comply with the contract requirements of the Federal Acquisition Regulation (FAR) and Veterans Affairs Acquisition Regulation (VAAR).

Mr. Frye will testify that by longstanding and massive circumvention of the FAR and VAAR in the fee basis authorization process, VA has illegally obligated billions of dollars. He will explain that, VA incurs billions in improper payments that represent material weaknesses in VA internal audit controls. Significantly, in 2009 and 2010, the OIG reported on serious problems with the accuracy and efficiency of claims paid though the fee basis program. The OIG reported that VA medical centers made hundreds of millions of dollars in improper payments—including duplicate payments and incorrect amounts. Most troubling is that VA had not established fraud prevention or detection controls because it didn't consider the program to be at significant risk. OIG estimated that VA could be paying as much as $380 million annually for fraudulent claims and in May 2014—contrary to VA's assertion that previous illegal purchases can be institutionally ratified—OIG reported that VA further violated the law by institutionally ratifying illegal purchases and avoiding important checks and balances.

Today, GAO's Director of Healthcare, Randall Williamson, will testify about the continuing limitations in oversight of healthcare service contracts and will focus particularly on the inadequate management of clinicians who provide services under contract within VA facilities. We will also hear from United States Army veteran,

Christopher Labonte, whose horrific experience with VA represents a case study in the risk associated with non-competitive contracts with affiliates and the importance of quality control and oversight of contract performance standards.

As I said in the purchase card hearing, violations of procurement laws are not mere technicalities. It is not just a matter of paying a little more for needed supplies and services as some apologists for VA have asserted. Among other things, without competition, business may be awarded based on cronyism and the directing of business to favored vendors, including those who may employ former VA officials. Without contracts, patient safety provisions are not legal requirements. VA's mismanagement of the fee basis program is not a justification to dispense with FAR and VAAR requirements. If the atom bomb can be built and wars conducted under the acquisition regulations, surely VA can deliver patient care under them as well.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

PREPARED STATEMENT OF EDWARD MURRAY

Good morning, Chairman Coffman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) provision of care to Veterans by contracting with community providers. I am accompanied today by Mr. Gregory Giddens, Principal Executive Director, Office of Acquisitions, Logistics and Construction (OALC), Mr. Jan Frye, Deputy Assistant Secretary for Acquisition and Logistics, Mr. Norbert Doyle, Chief Procurement and Logistics Officer for the Veterans Health Administration (VHA), and Ms. Phillipa Anderson, Assistant General Counsel.

Introduction

VA is a provider of healthcare services for Veterans. By statute, 38 United States Code (U.S.C.) § 1710, VA is authorized to provide "necessary" care to Veterans. With respect to hospital and outpatient care, VA has defined what is "necessary" by regulation, 38 Code of Federal Regulations (CFR) § 17.38, the medical benefits package. VA has been given authority, pursuant to 38 U.S.C. § 1703, to contract for that care. These contracts are governed by Federal acquisition statutes and the Federal Acquisition Regulations (FAR). This mix of in-house and community care provides Veterans the full continuum of health-care services covered under our available medical benefit offerings.

Last year VA in informal discussions with House and Senate Veterans Committee staff noted possible confusion regarding its purchased care authorities that would need to be addressed by statute. VA in its February budget noted the Department was putting forward a legislative proposal that would update its purchased care authorities to address confusion and uncertainty surrounding its current authorities. After a period of interagency discussions, VA on May 1, 2015, provided the House and Senate Veterans Affairs Committees with a formal proposal for comprehensive reform of its purchased care authorities, including very specific requirements for non-FAR based agreements.

VA Procurement: Care in the Community

Care in the community is used to augment VA provided healthcare in order to meet clinical demand as well as address wait times for providing medical services, while also considering patient convenience. When VA facilities are not capable of furnishing economical care because of geographic inaccessibility or otherwise are not capable of providing the care or services required, they may contract for hospital care or medical services in accordance with 38 U.S.C. § 1703. When the demand is for infrequent or limited use, VA, through the use of individual authorizations, as described in VA Acquisition Regulation 801.670-3, may purchase hospital care or medical services from the community. VA has had a 30 year practice of using individual authorizations without applying Federal acquisition processes and procedures. This practice allows Veterans to get the best care they can get in the most efficient way possible. VA's legal basis to use non-FAR based contracts to purchase care in the community for Veterans has been challenged. Because of possible confusion regarding the authority for this practice, VA sought to clarify the authority through proposed legislation, because VA believes this practice is critical to ensuring that veterans receive healthcare in a timely fashion, and from locations that are close to where they reside.

In FY 2006, we spent roughly $2.7 billion for care in the community. Since 2006, there has been a steady increase in individual authorizations for care in the community. In FY 2014, we spent over $7.0 billion, which represents an increase of 160 percent. This includes care purchased using individual authorizations, emergency care, and care purchased via FAR-based contracts, the majority of which was for services priced at or below comparable Medicare rates. However, VA often finds it difficult to purchase care at Medicare rates for specialty and primary care services in underserved areas. Currently, the FY 2015 estimate is approximately $10.4 billion, which represents an increase of 55 percent over the last year.

When VA issues an individual authorization for care in the community, regulations 38 CFR 17.55 and 38 CFR 17.56 are the relied upon payment authorities. Both regulations align VA with Federal government payments under the Medicare program for preauthorized outpatient and inpatient care to eligible Veterans. VA has a comprehensive internal audit program to review claims submitted by community providers. VHA's Chief Business Office conducts multiple audits to ensure proper eligibility determinations and accurate payment of claims for care in the community. VA's Office of Business Oversight, an audit office external to VHA, conducts enterprise-wide payment accuracy and internal control reviews of non-VA care claim payments.

Finally, VA acknowledges that our long-standing procurement processes for care in the community need improvement. We will continue to work to improve our procurement practices by identifying items that should be transitioned into national contracts, maximizing the use of current national contracts, adopting a standard nomenclature, and looking for best practices to be applied across the enterprise.

Purchased Healthcare Streamlining and Modernization Act

On May 1, 2015, VA submitted proposed legislation that would authorize the Secretary to enter into Veterans Care Agreements with providers, physicians and suppliers that have enrolled with Medicare and entered a provider agreement or participation agreement with Medicare; providers participating in Medicaid; and other providers the Secretary determines to be qualified. These agreements would provide relief from certain Federal contracting requirements, including competitive acquisitions procedures, but similar to VA's existing authority, payment rates for these agreements will be tied to comparable Medicare rates. Veterans Care Agreements will allow VA to provide care in a way that is similar to the operation of the Medicare and Medicaid programs as well as community care purchased for those eligible for care through the Veterans Choice program. The legislation is designed to provide a clear legal foundation for VA's continuing use of individual authorizations and provider agreements. At the same time, the legislation includes explicit protections for procurement integrity, provider qualifications, and price reasonableness. We note that Congress enacted a similar authority that is restricted to use in the Veterans Choice Program in Public Law (P.L.) 113–146, as amended by P.L. 113–175.

Many Veterans receive care under individual authorizations. If we were to stop providing these authorizations, it would impact a large number of Veterans by compromising immediate access to care and our community providers that we rely on to care for Veterans. Because small practices and individual providers of health services would not be willing to enter into complex procurement contracts just to treat one veteran, it is likely that veterans will be deprived of care that is best for them.

Enactment of this legislation will resolve what has emerged as serious legal questions in our purchased care authorities. Without this change, Veterans will lose access to many community providers across the board in primary care, specialty care, mental healthcare, and extended care.

Conclusion

In conclusion, VA strongly values its relationship with community providers. We realize the important role they play in assisting us in providing timely and high quality care to Veterans. Our priority always has been to put Veterans' health and well-being first. Without the use of individual authorizations, Veterans would not receive the care they need. We look forward to working with Congress toward enactment of the proposed legislation and the critical aspect of ensuring Veterans' timely access to healthcare.

Mr. Chairman, I appreciate the opportunity to appear before you today. My colleagues and I look forward to answering any questions you or other Members of the Committee may have.

PREPARED STATEMENT OF JAN R. FRYE

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, thank you for inviting me to testify today.

You have just heard Mr. Murray provide the Department's position on the illegal purchases of billions of dollars in non-VA care over multiple years. If you are not now confused, I am surprised. I would be completely confused if I were not familiar with the facts. We obviously do not intend to admit our collective failures in leadership and stewardship of public funds. Mr. Murray stated there was and is confusion, inconsistent application, and conflicting interpretations. As VA senior leaders, we have had many years to correct these deficiencies.

Mr. Murray also stated there were conflicting interpretations of the law. Here are some facts that may help you decide if conflicting interpretations exist. In October 2012, a very senior VHA official informed me trouble was looming, as they had been violating the law on a wholesale basis with regards to purchase of non-VA care. I asked him for details about legal documents he hinted of; he declined to reveal anything.

On October 22, 2012 I began a personal inquiry into the matter. I sent this same VHA senior official and his subordinate a written statement, addressing his plight, hoping I would receive additional information from him. He declined to respond.

On December 3, 2012, I sent a note to a senior executive from Office of General Counsel, requesting a legal opinion as to whether individual authorizations for non-VA care were considered FAR-based contracts. I received no response.

Receiving no response, I followed up again on Dec. 31, and for a third time on January 15, 2013.

On February 28, 2013, nearly three months after I requested the initial opinion, the Office of General Counsel provided me a legal opinion dated September 10, 2009. This opinion categorically declares procurements of non-VA, Fee Basis Care to be FAR-based. There is absolutely no confusion in this legal opinion, in spite of what you just heard to the contrary. Neither my predecessors nor myself have ever granted authority for VHA to acquire non-VA healthcare except by FAR-based methods.

You may wonder why, as VA's Senior Procurement Executive, I had never previously seen this legal opinion, and why there was such obvious reluctance to provide it to me. That is an enigma. Mr. Murray and myself testified under oath to this subcommittee in 2010, stating fee-basis care was not FAR based. If this legal opinion existed in 2009, why was it kept from us in preparation for the hearing?

Given the apparent recalcitrance to engage by VHA and Counsel, I submitted a Hotline Complaint to the Office of Inspector General in March 2013. The OIG initially refused my submission, questioning my motive for submitting the complaint. I stubbornly persevered, and they subsequently accepted it. I am unaware OIG ever investigated.

In April 2013, I requested senior leadership assistance from VHA and the Office of General Counsel, in conducting ratification actions for these massive violations of Federal law. I received no offer of assistance from either office.

In May 2013, Secretary Shinseki was briefed on non-VA care authority options. He was made aware of our illegal actions. I was not invited to the meeting.

In June 2013, I wrote a letter to Representative Issa, then serving as Chairman of the House Oversight and Government Reform Committee, outlining my concerns in these illegal matters and others. My letter never made it to him. Two senior officials who are apparent friends, one from the House Oversight Committee, and one from VHA, conspired to keep Chairman Issa and the American public from learning of these matters and other serious VA violations of Federal laws.

In April 2014, the VA Senior Assessment Team voted to close ongoing discussions of illegal purchases of non-VA medical care, with mine as the lone opposing vote. In that same meeting, the VA Office of Management sponsored a motion, which passed, to raise the reporting level for VA material weaknesses from approximately $400M to $1B. I believe this was an effort to avoid reporting emerging illegal matters to the American public through the annual statement of assurance process.

In July 2014 I was threatened and coerced on multiple occasions in a two-hour meeting headed by the VA Chief of Staff, in an effort to force me to authorize illegal actions on a major scale concerning fee-basis care.

From July to November 2014, we collaboratively developed a legally sufficient method to acquire non-VA healthcare. VHA's senior leadership rejected the method in November 2014. The illegal activity continues unabated.

This past Friday, Deputy Secretary Gibson elected to make my disclosure of these and other illegal acts a personal issue with me. His demeanor and actions in both an open and one-on-one meeting were clearly meant to intimidate me, and to cast a chill over me and others who might be tempted to report violations in the future.

I will allow you and the court of public opinion to decide for yourselves if what I have briefly described constitutes corruption, malfeasance or dereliction. No investigation has been conducted. No ratifications of illegal procurements have been executed. Improper payments continue. Veterans receive healthcare without protection of mandatory terms and conditions. No one is liable.

I believe these are two relevant questions: How can we hold subordinate VA employees accountable, if we as senior leaders selectively pick and choose the laws we want to observe for sake of convenience? When will VA senior leaders be held accountable? There were more than a dozen of VA's most senior leaders in the July 11, 2014 meeting. The issue of illegality was positively affirmed. Not a single leader present, save one, subsequently acted in any way to protect the Government's interests or resources.

We have lost our way. Senior leaders are required to obey and enforce Federal laws. Our actions and inactions do not fit anything I have previously experienced in over 40 years as a Military Officer and civilian public servant.

Mr. Chairman, this concludes my statement. I am prepared to answer all questions this Subcommittee may have for me.

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 4:00 p.m. ET
Monday, June 1, 2015

VA HEALTH CARE

Actions Needed to Improve Monitoring and Oversight of Non-VA and Contract Care

Statement of Randall B. Williamson
Director, Health Care

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Department of Veterans Affairs' (VA) delivery of care through both its Non-VA Medical Care Program and clinical contracts.[1] The majority of veterans enrolled in the VA health care system receive care in VA-operated medical facilities, such as VA medical centers and community-based outpatient clinics.[2] However, in order to meet the needs of the veterans it serves, VA is authorized to obtain health care services from non-VA providers through both the Non-VA Medical Care Program and clinical contracts.[3] These two mechanisms for accessing non-VA providers help to augment VA's delivery of services to veterans in different ways. The Non-VA Medical Care Program allows VA to deliver care to veterans in non-VA facilities, such as physicians' offices and hospitals in the community, and pay for this care using a fee-for-service arrangement.[4] Clinical contracts are used by VA to bring non-VA providers—such as physicians, pharmacists, and nurses—into VA facilities to provide services to veterans. These contracts can be used to fill vacancies for clinicians in specialties that are difficult to recruit, supplement existing VA capacity by providing additional clinicians in high-volume areas, or fill critical staffing vacancies on a long- or short-term basis. According to VA, every VA facility has at least one clinical contract in place to help supplement the number of providers working in VA medical facilities.

VA's spending on the Non-VA Medical Care Program and the number of veterans receiving care from non-VA providers have both risen significantly in recent years. From fiscal year 2008 to fiscal year 2013, VA spending on non-VA medical care rose from about $3 billion to about

[1]The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

[2]VA's health care system includes medical centers, VA-operated community-based outpatient clinics, community living centers (nursing homes), residential rehabilitation treatment programs, and comprehensive home care programs.

[3]VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

[4]For example, VA may utilize non-VA medical care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or when a veteran would have to travel long distances to obtain care at a VA medical facility.

$4.8 billion. Since 2013, VA has added two new components to its Non-VA Medical Care Program—the Choice Program and Patient-Centered Community Care (PC3).[5] With the addition of these new components, it is anticipated that the number of veterans seeking care through the Non-VA Medical Care Program will continue to grow. As such, it is increasingly important for VA to incorporate robust oversight and accountability into the administration of the program to address inefficiencies in non-VA medical care delivery highlighted in recent reports by GAO and others.[6]

VA's oversight of clinical contracts used throughout the VA health care system has also been shown to be limited. Previous studies highlighted challenges VA has faced developing and administering its clinical contracts. In recent years, for example, the VA Office of the Inspector General highlighted challenges VA faces in developing its clinical contracts and found systemic weaknesses in the process VA uses to award contracts.[7] These weaknesses were attributed to VA's decentralized oversight of the initial stages of the contracting process before a contract is awarded to a contractor. In an October 2013 report, we found that VA's oversight of clinical contractors is inadequate once a

[5]The Veterans Access, Choice, and Accountability Act of 2014 provided new authorities, funding, and other tools to help with the reform of the VA health care system. Through this Act, Congress provided $10 billion in additional funds to VA to under certain conditions expand its ability to provide non-VA medical care to certain veterans, such as veterans that are unable to get an appointment with a VA provider within 30 days of either their desired or clinically appropriate date or live more than 40 miles from the nearest VA facility. This funding is available for VA's use through August 7, 2017 or until its exhaustion, whichever comes first. PC3 is a nationwide VA program that established two nationwide contracts with Health Net and TriWest to establish networks of providers that can provide care through the Non-VA Medical Care Program in a number of specialties—including primary care, inpatient specialty care, and mental health care. Pub. L. No.113-146, 128 Stat. 1754 (2014).

[6]See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, GAO-14-175 (Washington, D.C.: Mar. 6, 2014) and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, GAO-13-441 (Washington, D.C.: May 31, 2013). See also, Department of Veterans Affairs Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, 08-02901-185 (Washington D.C.: Aug. 3, 2009). See also National Academy of Public Administration, *Veterans Health Administration Fee Care Program* (Washington, D.C.: September 2011).

[7]See Department of Veterans Affairs Office of Inspector General, *Audit of Veterans Integrated Service Network Contracts*, 10-01767-27 (Washington, D.C.: Dec. 1, 2011) and Department of Veterans Affairs Office of Inspector General, *Audit of VA Electronic Contract Management System*, 08-00921-181 (Washington, D.C.: July 30, 2009).

contract is awarded and contract providers begin caring for veterans in VA facilities.[8]

Today, I will summarize the results of recent GAO work examining weaknesses in the oversight of VA's Non-VA Medical Care Program and clinical contracts. Specifically, I will address the extent to which (1) VA monitors and oversees its Non-VA Medical Care Program and (2) VA monitors and oversees clinical contracts and the work of contracted non-VA providers working in VA facilities.[9] My comments are based on reports we issued in March 2014 and May 2013 examining the Non-VA Medical Care Program, and October 2013 examining clinical contracts.[10]

For the March 2014 report, which focused on VA's administration and oversight of emergency care for conditions not related to veterans' service-connected disabilities provided under the Veterans Millennium Health Care and Benefits Act (Millennium Act) and delivered to veterans by non-VA providers, we reviewed the law, its implementing regulations, and applicable VA policies and guidance to identify applicable requirements for processing these claims.[11] We then visited four VA facilities that were selected on the basis of fiscal year 2012 spending totals and geographic location and reviewed VA documents—including 128 emergency care claims for veterans with non-service connected conditions that these four facilities had denied in fiscal year 2012. We also interviewed officials from VA, non-VA providers, and veterans' service organizations.

[8]See GAO, *VA Health Care: Additional Guidance, Training and Oversight Needed to Improve Clinical Contract Monitoring*, GAO-14-54 (Washington, D.C.: Oct. 31, 2013).

[9]Because the Choice Program and PC3 are recently-added components to VA's Non-VA Medical Care Program and we have not reviewed them, this statement will be confined to discussing existing non-VA medical care delivery mechanisms that existed prior to 2013. To date, Choice Program and PC3-related claims represent a small portion of the $4.8 billion VA currently spends on non-VA provider care.

[10]See GAO-14-175, GAO-13-441, and GAO-14-54.

[11]The Millennium Act authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other specified criteria. See Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (codified, as amended, at 38 U.S.C. § 1725).

For the May 2013 report, which focused on VA's management and oversight of non-VA medical care spending and utilization, we reviewed relevant laws and regulations, VA policies, and spending and utilization data on non-VA medical care from fiscal years 2008 through 2012. We also interviewed VA officials and examined the non-VA medical care operations at six selected VA facilities that varied in size, services offered, and geographic location. The results of both of these studies cannot be generalized to all VA facilities, but illustrate the serious weaknesses in various aspects of the Non-VA Medical Care Program.

For the October 2013 report, which focused on VA's monitoring and oversight of clinical contracts and contractors, we reviewed relevant laws, regulations, and VA policies. We also interviewed VA officials and examined clinical contract monitoring efforts in place—including an in-depth review of 12 clinical contracts—at four selected VA facilities that varied in the types of clinical contracts used and geographic location. The results of this study cannot be generalized to all VA facilities, but illustrates serious weaknesses in VA's monitoring and oversight of non-VA providers caring for veterans in VA facilities through clinical contracts.

We have made 22 recommendations to VA in these previous reports, and VA concurred with all of them. We are not making any new recommendations at this time. From January to May 2015, we periodically met with VA officials to discuss the status of VA's implementation of the recommendations in these three reports.

The work this statement is based on was conducted in accordance with generally accepted government accounting standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The reports cited provide additional information on our scope and methodology.

Background

Non-VA Medical Care Program

There are two main non-VA medical care delivery methods—preauthorized care and emergency care—that are approved using two different processes. The first, preauthorized care, is approved in advance by VA facility officials. VA may authorize veterans to seek care from non-VA providers for a number of reasons, including when (1) wait times for appointments at VA facilities exceed VA standards; (2) the distance veterans must travel to VA facilities is impractical for the veteran; and (3) VA facilities do not offer the medical services the veteran needs. Preauthorized care accounts for the majority of spending and utilization (about 60 percent of spending and about 88 percent of utilization) for the Non-VA Medical Care Program. The second, emergency care, is not typically approved in advance by VA facility officials and has certain criteria that must be met in order for VA to approve reimbursement for the non-VA provider. (See table 1.)

Table 1: Types of Non-VA Medical Care Claims and Relevant Payment Authority

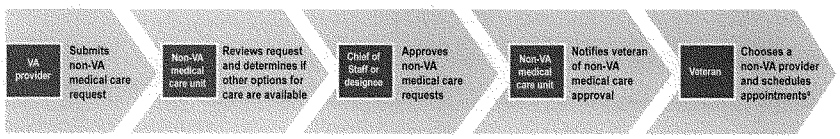
Type of claim	Description and relevant payment authority
Preauthorized care[a]	Services with prior VA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)
Emergency care	Services without VA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash)
Veterans Millennium Health Care and Benefits Act (emergency care for conditions not related to service-connected disabilities)	Services meeting criteria under 38 U.S.C. § 1725
Emergency care for conditions related to service-connected disabilities	Services meeting criteria under 38 U.S.C. § 1728

Source: GAO analysis of VA policies. | GAO-15-654T.

[a]In certain circumstances, emergency care provided by non-VA providers can be deemed preauthorized if the non-VA providers provide notification of a veteran's admission within 72 hours. Emergency care by non-VA providers may also be preauthorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA facility.

Preauthorizing non-VA medical care involves a multistep process conducted by the VA facility that regularly serves a veteran.[12] The preauthorization process is initiated by a VA provider who submits a request for non-VA medical care to the VA facility's non-VA medical care unit, which is an administrative department within each VA facility that processes VA providers' non-VA medical care requests and verifies that non-VA medical care is necessary. Once approved by the VA facility's Chief of Staff or his or her designee, the veteran is notified of the approval and can choose any non-VA provider willing to accept VA payment at predetermined rates.[13] (See fig. 1.)

Figure 1: Department of Veterans Affairs (VA) Facility Process for Preauthorizing Non-VA Medical Care



Source: GAO. | GAO-15-654T

[a]In some VA facilities the non-VA medical care unit may assist veterans in setting up their appointments with the non-VA provider of their choice.

Regardless of whether a veteran's non-VA medical care was preauthorized or the result of an emergency, the steps for processing payments to non-VA providers are the same. Specifically, the non-VA provider submits a claim to either a Veterans Integrated Service Network (VISN) or a VA facility for payment following the veteran's treatment.[14] In some VISNs, claims processing activities are centralized in a VISN-level

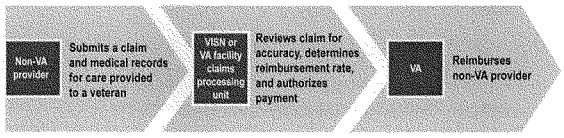
[12]VA uses this same preauthorization process for nonemergency inpatient and outpatient care, dental care, nursing home care, compensation and pension exams, and most pharmacy expenses paid for through the non-VA medical care program.

[13]VA uses this process to preauthorize non-VA medical care from a number of different types of non-VA providers, including community-based hospitals and Department of Defense medical facilities that collaborate with VA facilities to provide some veterans' care.

[14]VHA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA facilities that are within their network. Each VA facility is assigned to a single VISN.

department that is responsible for reviewing claims from non-VA providers, obtaining copies of medical records for veterans' non-VA medical care, and approving payment to non-VA providers. In other VISNs, these claims-processing activities are decentralized and are the responsibility of individual VA facilities. After VA facility or VISN officials review the claims for accuracy, non-VA providers are reimbursed by VA. (See fig. 2.)

Figure 2: Veterans Integrated Service Network (VISN) or Department of Veterans Affairs (VA) Facility Steps for Processing Approved Claims for Non-VA Medical Care



Source: GAO. | GAO-15-654T

Note: In November 2014, VA completed an organizational realignment and reassigned all VA VISN- and facility-based claims processing staff to VA Central Office. However, VA Central Office has not centralized the location of these staff and they continue to work within the VISNs and VA facilities to which they previously reported.

To process all claims for non-VA medical care, VA facilities must enter information into the non-VA medical care claims processing system. This system helps VA facilities administer payments to non-VA providers, as opposed to a system that automatically applies relevant criteria and determines whether claims are eligible for payment. As a result, VA relies on staff in the VISNs and VA facilities that process claims, such as administrative clerks and clinicians (typically nurses), to make decisions about which payment authority applies to the claim and which claims meet the criteria for VA payment.

If VA denies payment for a claim for non-VA medical care, the agency must provide written notice to the veteran and the claimant (usually, the non-VA provider) regarding the reason for the denial and inform them of their rights to request a reconsideration or to formally appeal the denial. If a veteran or non-VA provider has questions about a denied claim, claims should be reconsidered by a supervisor at the same VISN or VA facility that denied the claim. If the denial decision is upheld, the veteran or non-

VA provider has the right to file an appeal through the Board of Veterans' Appeals.[15]

VA Clinical Contracting

Both acquisition and clinical staff at VA work together to plan, execute, and monitor clinical contracts at VA. On the acquisition side, contracting officers (CO) are responsible for planning, awarding, and administering contracts on behalf of the federal government. Each CO is authorized to obligate federal funds up to a specified limit and a CO must formally approve all clinical contracts at VA. Common tasks of a CO include developing acquisition planning documents used to begin a clinical contract, conducting market research to determine pricing and availability for a clinical contract, and completing the formal competitive or non-competitive solicitation process for contracts. Each CO works within a network contracting office and is overseen by managers within that office who report directly to VA Central Office. There are 21 network contracting offices throughout VA's health care system that manage all the contracting activities of a single VISN.[16]

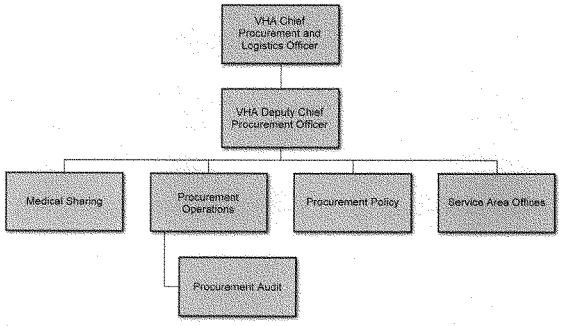
For each VA clinical contract, the CO responsible for the contract designates a contracting officers' representative (COR) at the VA facility to help develop the clinical contract and monitor the contract provider's performance once the provider begins work. Common tasks delegated to the COR include providing input on the performance requirements for the clinical contract, determining how the contract provider's performance will be measured and monitoring performance once work has begun, validating the contract provider's invoices to ensure their accuracy, managing contract modifications, and assisting the CO in resolving any issues that may arise with the contract provider. At VA, CORs are commonly administrative personnel responsible for managing the operations of a specialty care line at a VA facility—such as primary care and surgery—where the contractor will be working. CORs are responsible for maintaining the official record of the contract provider's performance and providing official performance assessments to the CO.

[15]Based in Washington, D.C., the Board of Veterans' Appeals is composed of judges experienced in veterans' law. The Board reviews benefit determinations made by local VA offices and issues final decisions on appeals.

[16]While network contracting offices manage the contracting activities of a single VISN, they are managed by VA Central Office regional contracting management entities and have no managerial link to VISN leadership.

VA Central Office has primary responsibility for overseeing network contracting offices and manages clinical contracting activities through the Veterans Health Administration (VHA) Procurement and Logistics Office.[17] There are five primary offices within the VHA Procurement and Logistics Office that are responsible for overseeing various aspects of clinical contracting activities and report to VHA's Deputy Chief Procurement Officer. (See fig. 3.)

Figure 3: Organization of the Veterans Health Administration (VHA) Procurement and Logistics Office



Source: GAO analysis of VA information. | GAO-15-654T

Medical Sharing Office. The Medical Sharing Office is responsible for providing guidance to network contracting offices regarding the content and structure of solicitations for clinical contracts and for reviewing several types of clinical contracts. The Medical Sharing Office reviews solicitations of all competitive clinical contracts valued at over $1.5 million, all non-competitive clinical contracts valued at over $500,000, and all organ transplant contracts.[18] All Medical Sharing Office reviews are

[17]VHA is the VA entity responsible for overseeing VA's health care operations.

[18]The Medical Sharing Office does not review any contracts for nursing services. Nursing contracts are processed and reviewed by another contracting entity in VA.

conducted before a solicitation is issued to ensure that all the necessary provisions are in place prior to any competition or award.

Procurement Operations Office. The Procurement Operations Office is responsible for providing ongoing guidance and monitoring of the COR population at VA. The Procurement Operations Office conducts reviews of COR files and publishes a COR newsletter.

Procurement Audit Office. The Procurement Audit Office is responsible for ensuring compliance with VA policies and procedures related to contracting. This office conducts internal compliance audits of contracts, including clinical contracts, once they are executed to ensure that all required documentation was included in the final contract and audits the activities of network contracting offices and Service Area Offices (SAO) to ensure their compliance with VA policies and regulations.

Procurement Policy Office. The Procurement Policy Office is responsible for providing guidance to VA's acquisition workforce in network contracting offices and SAOs. This office produces and updates standard operating procedures for CORs and COs.

Service Area Offices. SAOs are the regional contract management entities created to oversee the activities of the 21 network contracting offices and the COs and supervisors that work within them. VHA created three SAOs—East, West, and Central—to manage the contracting activities of six to eight VISNs each. SAOs review solicitations for most clinical contracts during their initial stages to ensure that all necessary provisions are in place prior to any competition or award.

Significant Weaknesses Exist in VA's Monitoring and Oversight of Non-VA Medical Care

VA Lacks Critical Data on Wait Times and Cost-Effectiveness of Non-VA Medical Care

As our recent work has found, critical data limitations related to the wait times veterans face in obtaining care from non-VA providers and the cost-effectiveness of such services hinder VA's efforts to oversee the Non-VA Medical Care Program in an effective manner.

VA does not collect data on how long veterans must wait to be seen by non-VA providers. We previously found that the amount of time veterans wait for appointments in VA facilities influenced VA's utilization of non-VA medical care. For example, in our May 2013 report, VA officials from all six facilities we reviewed reported that they routinely referred veterans to non-VA providers to help ensure that veterans receive timely care and their facilities meet performance goals for wait times for VA facility-based care.[19] Officials from one of these VA facilities explained that veterans needing treatment in several specialties—including audiology, cardiology, and ophthalmology—were referred to non-VA providers for this reason.

In fiscal year 2012, VA performance goals for wait times for care in VA facilities called for veterans' primary care appointments to be completed within 7 days of their desired appointment date and veterans' specialty care appointments to be scheduled within 14 days of their desired appointment date. However, since VA did not track wait times for non-VA providers, we found that little was known about how often veterans' wait times for non-VA medical care appointments exceeded VA facility-based appointment wait time goals. Officials from one VA facility we reviewed explained that non-VA providers in their community also faced capacity limitations and may not be able to schedule appointments for veterans any sooner than the VA facility.

[19]See GAO-13-441. These six facilities were located in Durham and Salisbury, NC; Alexandria, LA; Biloxi, MS; Las Vegas, NV; and Loma Linda, CA.

We recommended in May 2013 that VA analyze the amount of time veterans wait to see non-VA providers and apply the same wait time goals to non-VA medical care that have been used to assess VA facility-based wait times. VA concurred with this recommendation and detailed its plan to create a national consolidated monthly wait time indicator to measure performance for non-VA medical care referrals. In February 2015, VA reported that this monthly indicator had been developed and rolled out as a part of the Non-VA medical care coordination initiative. This monthly indicator tracks the number of veterans whose appointments with a non-VA provider are scheduled within 90 days—including generating the veterans' authorization to receive the care, scheduling the appointment with the non-VA provider, and receiving the veterans' medical records from the non-VA provider after the appointment is held. However, this indicator only partially implements our recommendation because it does not use the same wait time measures for non-VA medical care as are used for VA facility-based care.

VA Cannot Analyze the Cost-Effectiveness of Non-VA Medical Care

Our recent work found that limitations in the way VA collects non-VA medical care data did not allow the Department to analyze the cost-effectiveness of non-VA medical care provided to veterans. As we reported in May 2013, we found that VA lacked a data system to group medical care delivered by non-VA providers by episode of care—a combined total of all care provided to a veteran during a single office visit or inpatient stay.[20] For example, we reported that during an office visit to an orthopedic surgeon for a joint replacement evaluation, an X-ray of the affected joint may be ordered, the veteran may be given a blood test, and the veteran may receive a physical evaluation from the orthopedic surgeon. The non-VA provider would submit a claim to VA for the office visit and the radiologist that X-rayed the affected joint and the lab that performed the veteran's blood test would submit separate claims. However, VA's non-VA medical care data system was not able to link the charges for these three treatments together. We found that this left VA

[20]In March 2013, VA officials told us that for inpatient claims they could construct a program to group inpatient ancillary claims together by linking all the records of individual services provided to veterans during a particular date range. However, this method relies on correct data entry by VISNs and VA facilities into the non-VA medical care claims processing system and on correct information furnished by non-VA providers. VA officials acknowledged that there is no way to link outpatient services together to create a record of a single outpatient episode of care.

without data for comparing the total non-VA medical care costs for various types of services with the VA facility-based alternative.

Without cost-effectiveness data, we concluded that VA is unable to efficiently compare VA and non-VA options for delivering care in areas with high utilization and spending for non-VA medical care. Two VA facilities we reviewed had undertaken such assessments of whether services should be provided through non-VA medical care or through an expansion of facility-based care, despite the limitations of current data.[21] Officials at one facility reported that they expanded their operating room capacity to reduce their reliance on non-VA surgical services, saving an estimated $18 million annually in non-VA medical care costs. Similarly, officials from the second facility reported that they were able to reduce their reliance on non-VA medical care by hiring additional VA staff and purchasing additional equipment to perform pulmonary function tests, an effort that reduced related non-VA medical care costs by about $112,000 between fiscal years 2010 and 2012. We also found that the lack of non-VA medical care data available on an episode of care basis prevents VA from efficiently assessing the appropriateness of non-VA provider reimbursement. Specifically, VA officials cannot conduct retrospective reviews of VA facilities' claims to determine if the appropriate rate was applied for the care provided by non-VA providers.

We recommended in May 2013 that VA establish a mechanism for analyzing the episode of care costs for non-VA medical care. VA concurred with this recommendation and noted that the Department agrees that analyzing episode of care costs is an important part of its non-VA medical care monitoring activities. In February 2015, VA reported that a mechanism to analyze non-VA medical care costs on an episode of care basis would not be instituted until a planned redesign of the Department's non-VA medical care data systems is completed in fiscal year 2016. As a result, this recommendation remains unimplemented.

[21]Both these facilities conducted these analyses as part of efforts to reduce their reliance on non-VA medical care. Such decisions require careful analysis of the benefits and costs of the expansion of VA facility-based services. Before a VA facility expands its capacity, VA requires the facility to develop a business case for the expansion as part of VA's annual consideration of capital investments. These business cases must address several elements—including a financial analysis and safety issues. See Department of Veterans Affairs, *Strategic Capital Investment Planning Process*, VA Handbook 0011 (Aug. 8, 2011).

VA Lacks Automated Processes for Monitoring Non-VA Medical Care Claims Processing and Has Limited Oversight Mechanisms for Validating VA Facility Actions

Our recent reports have found that crucial limitations exist in VA's monitoring and oversight of non-VA medical care claims processing. Specifically, VA does not have automated systems to help VA facility-based claims processing staff determine whether a non-VA medical care claim is eligible for payment or notifying veterans that their claims have been denied.[22] In addition, VA's oversight mechanisms—including field assistance visits to VA facilities processing non-VA medical care claims and audits of VA facilities' claims determinations—are limited due to weaknesses in their execution.

As we reported in March 2014, we found that there were no automated processes for determining whether a claim for non-VA medical care meets criteria for payment or ensuring that veterans are notified when a claim is denied.[23] Instead these processes rely largely on the judgment and diligence of VA facility-based claims processing staff reviewing each claim and their adherence to VA policies. We found that there were a number of steps in the claims review process that were susceptible to errors that could lead to inappropriate denials of non-VA medical care claims. For example, we found nine instances where a veteran's claim was denied under VA's emergency care authority for non-service connected conditions, but should have been paid under VA's preauthorized non-VA medical care authority because a VA clinician had

[22]In November 2014, VA completed an organizational realignment and reassigned all VA VISN- and facility-based claims processing staff to VA Central Office. However, VA Central Office has not centralized the location of these staff and they continue to work within the VISNs and VA facilities to which they previously reported.

[23]See GAO-14-175. We examined a sample of 128 emergency care claims for veterans' non-service connected conditions that had been denied by VA facility claims processing staff at four VA facilities in fiscal year 2012. For our March 2014 report, we visited VA facilities in Dallas, TX; Washington, DC; White River Junction, VT; and Fort Meade, SD. We found 66 instances of noncompliance with VA policy requirements, determined that about 20 percent of the claims we examined had been denied inappropriately, and found that almost 65 percent of the claims we examined lacked documentation showing that the veteran was notified that their claim was denied. As a result of our review, the four VA facilities we visited reconsidered and paid 25 claims that they had previously inappropriately denied.

referred the veteran to the non-VA provider.[24] We found that in eight of these nine cases, VA facility-based personnel failed to complete critical steps in the non-VA medical care authorization process that impacted the information available to claims processing staff later in the process and without an automated process to prompt these claims processing staff to check for additional information, these claims were inappropriately denied.

In addition, according to VA policy, the Department must notify veterans in writing about denied claims and their appeal rights. However, as we reported in March 2014, we found that one VA facility we visited could not produce documentation of veteran notification for any of the 30 denied claims we reviewed. We concluded that when veterans are not informed that their claims for non-VA medical care have been denied and VA has inappropriately denied the claims, veterans could become financially liable for care that VA should have covered. Under such circumstances, veterans' credit ratings may be negatively affected and they may face personal financial hardships if they are unable to pay the bills they receive from non-VA providers. Taken together, the absence of systematic processes for completing these actions significantly reduces the assurance VA Central Office has that VA facility-based claims processing staff can consistently make accurate determinations about whether or not to pay non-VA medical care claims and notify veterans of their appeal rights in the case of denials.

In March 2014, we made six recommendations aimed at improving VA's processing of non-VA medical care claims, specifically emergency care claims for conditions not related to veterans' service-connected disabilities. These recommendations directed the Department to establish or clarify its policies and take other actions to improve VA facilities' compliance with existing policy requirements. VA concurred with these six recommendations. Based on updates we have received on VA's implementation of these recommendations, we believe VA has fully

[24]In eight of these nine instances, VA clinicians did not properly document their referrals in VA's electronic medical record, as required by VA policy. As a result, non-VA medical care unit staff were not alerted to create authorizations for this care in the non-VA medical care claims processing system, which is a necessary step for the payment of preauthorized non-VA medical care claims. In the remaining instance, staff who processed the claim did not have access to any authorizations in the non-VA medical care claims processing system that had been issued by other VA facilities and did not know that a VA clinician from a different VA facility had referred the veteran to the non-VA provider.

implemented two of the six recommendations related to properly dating incoming claims and verifying that claims are submitted to the correct VA facility. However, we believe that for the remaining four of these recommendations, additional steps are needed to revise VA policies on claims processing roles and responsibilities. These unimplemented recommendations are related to VA's non-VA medical care policies and procedures for processing claims and notifying veterans when claims are denied.

One of VA's primary methods for monitoring its facilities' compliance with non-VA medical care claims processing requirements is field assistance visits. As we reported in March 2014, we found a number of limitations in their use as an oversight mechanism. First, we found that VA's criteria for selecting facilities for field assistance visits may not direct VA to those facilities most in need of this oversight because VA does not take into account the accuracy of claims processing activity when selecting facilities for review. Instead, we found that VA selected the 30 VA facilities that received a field assistance visit in fiscal year 2013 based on their claims processing timeliness.[25] With a limited focus on the timeliness of claims processing and without attention to the accuracy of claims decisions, we concluded that VA Central Office does not have the opportunity to assist VA facilities in making accurate decisions that may impact veterans financial well-being. Second, we found that the checklist VA uses for its field assistance visits does not examine all practices that could lead VA facilities to inappropriately deny claims. For example, VA's checklist does not examine VA facilities' practices for determining whether veterans are enrolled at a different VA facility and whether they have been seen by providers at another VA facility in the last 24 months—a critical criterion for determining whether veterans are eligible for emergency care coverage for non-service connected conditions. Finally, we found that VA does not hold facilities accountable for correcting deficiencies identified during these visits, and it does not validate facilities' self-reported corrections to deficiencies identified during these visits. Specifically, in our review of fiscal year 2012 and 2013 field assistance visit data, we found that some VA facilities had unresolved

[25]In fiscal year 2013, there were 140 VA facilities that processed non-VA medical care claims.

problems in their fiscal year 2013 field assistance visit that had originated and were identified during their fiscal year 2012 field assistance visit.[26]

In March 2014, we made two recommendations aimed at revising the scope of field assistance visits and ensuring that deficiencies identified during these visits are corrected. VA concurred with both of these recommendations. VA has made some progress in implementing these recommendations as of May 2015 by expanding the topics covered during field assistance visits and updating their standard operating procedures. However, we believe that VA needs to undertake additional actions to sufficiently address them. Specifically, VA needs to ensure field assistance visits include a review of a sample of processed claims in order to determine whether staff are complying with claims processing requirements.

Our recent work has also found that VA has no systematic process for auditing claims to ensure that they were appropriately approved or denied. VA officials stated that they recommend, but do not require, that managers of VA facility-based non-VA medical care claims processing units audit samples of processed claims—including both approved and denied claims—to determine whether staff processed claims appropriately. However, in March 2014 we found that VA did not know how many VA facilities conducted such audits and none of the four VA facilities we visited reported conducting them.

Therefore, in March 2014, we recommended that VA institute systematic audits of the appropriateness of claims processing decisions. VA concurred with this recommendation and has made some progress implementing it as of May 2015 by instituting audits of some paid claims. However, we believe that to fully implement this recommendation, VA needs to undertake additional action. Specifically, VA needs to establish systematic audits of claims processing decisions—including both approvals and denials—made by VA facility-based claims processing staff.

[26]For example, when we reviewed these data, we found that one VA facility had been cited in fiscal year 2012 because it was not entering authorizations for referrals to non-VA providers in a timely fashion into VA's non-VA medical care claims processing system—a practice that could lead to the inappropriate denial of claims. We noted in our review of fiscal year 2013 field assistance visit data for this facility that this same deficiency had been observed again that year, even though facility officials had reported after the previous year's visit that the problem had been resolved.

Significant Limitations Exist in VA's Monitoring and Oversight of Clinical Contracts and Contractors

Contract Monitoring Is Limited by Heavy COR Workloads and Inadequate Training

As we reported in October 2013, we found that CORs cited two challenges that may compromise VA's monitoring of contractors' performance—the heavy workload associated with the COR position and the lack of adequate training for CORs.

Relating to workload, CORs at the four VA facilities we visited for our 2013 review consistently reported facing significant challenges in effectively carrying out their COR responsibilities for monitoring clinical contractors.[27] One challenge cited by the majority of CORs we met with (37 of 40 that completed our data collection instrument) was the assignment of the COR role as a collateral duty.[28] Many of these CORs' primary positions require them to manage staff, maintain budgets, and oversee other clinical providers. We found that the average COR spends about one-quarter of his or her time monitoring approximately 12 contracts, according to estimates provided by the CORs; however, some of these CORs were responsible for overseeing significantly more contracts. For example, we found that 6 of these 40 CORs managed nearly 190 of the 452 (41 percent) contracts in place at the four VA facilities we reviewed and told us they estimated spending at most 30 percent of their work time on their COR duties. In addition, we found that the CORs responsible for managing the 12 contracts we reviewed in depth frequently did not have the time to effectively monitor the performance of contract providers. Specifically, CORs for 8 of the 12 contracts reported that the demands of their primary positions had at times prevented them from fully monitoring contract providers'

[27]For our October 2013 review, we visited VA facilities in in Lebanon, PA; Minneapolis, MN; Nashville, TN; and Seattle, WA.

[28]We administered this data collection instrument to all CORs with responsibility for clinical contracts at the four VA facilities we visited.

performance. In addition, CORs for 6 of these 12 contracts stated that they could not complete certain elements of their COR responsibilities—such as adequately monitoring contract costs—due to limited time and resources.

VA guidance requires VA facilities to provide CORs with the time to complete their responsibilities and ensure that contract compliance is managed by a knowledgeable COR. Specifically, VA's standard operating procedure for CORs requires VA facilities to provide CORs with the time and resources necessary to complete required training and fulfill their duties as a COR.[29] In addition, to monitor clinical contracts effectively, CORs are required to perform a number of key functions—including completing quarterly reports on contract progress, quality assurance, and invoice audits. However, we found that VA's guidance related to COR responsibilities did not include any information on how VA facilities are to determine the feasibility of whether a COR's workload—including both COR and primary position responsibilities—will allow them to carry out their tasks as CORs for monitoring contract provider performance. The COR standard operating procedure also did not provide any guidance for determining when COR duties should be assigned as a collateral duty or a full-time responsibility. We concluded that without clear guidance on how to determine a COR's workload, VA facilities can unintentionally assign COR duties to a staff member who does not have the time available to properly monitor clinical contractors. If CORs' workloads prevent proper monitoring of clinical contracts, VA risks missing the opportunity to proactively identify and correct performance issues with contract providers and to recognize patient safety concerns potentially resulting from contract providers' actions. By failing to identify performance concerns with contract providers, VA could unknowingly be receiving sub-standard service from these contractors, continue to receive services from these contract providers that do not meet the needs of the VA facilities, and risk patient safety problems when these contracts are extended for additional years.

In October 2013, we recommended that VA revise its standard operating procedures for CORs to provide guidance on the number of contracts,

[29]See Veterans Health Administration, *Standard Operating Procedure: Contracting Officer Technical Representative*, (May 20, 2011). See also Department of Veterans Affairs Directive 1663, *Health Care Resources Contracting – Buying Title 38 U.S.C. 8153*, (Aug. 10, 2006).

based on size and complexity, each COR should manage to ensure that all CORs maintain a workload that allows them to fulfill their duties as a COR and their primary position responsibilities. VA concurred with this recommendation and detailed plans to revise existing COR standard operating procedures to include guidance on the number of contracts, based on size and complexity, that each COR should manage to ensure that all CORs maintain a workload that allows them to fulfill their duties as a COR and their primary position responsibilities. However, in April 2015, VA Central Office officials informed us that the Department no longer plans to revise these standard operating procedures in this manner, and plans instead to place language in the COR nomination letter that states that the COR and their supervisor discussed their workload and determined they could effectively serve as the COR for the contract. We believe that to fully implement our recommendation, VA needs to provide guidance to CORs and their supervisors through a revision to the COR standard operating procedures that provides guidance on the number and type of contracts each COR should manage to ensure that VA facilities and CORs can better make these determinations.

Relating to training, CORs from the four VA facilities we visited noted weaknesses in VA's COR training courses and our own analysis of these courses confirmed these limitations.[30] Specifically, over half of the 40 CORs from the four VA facilities we visited for our October 2013 review responded that either their COR training did not prepare them for their role as a COR or were neutral on whether or not this training was helpful preparation. In addition, CORs for 8 of the 12 contracts we reviewed in depth did not find the required COR training helpful or applicable to VA clinical contracting. For example, one COR stated that the training covered very broad areas of contracts and did not include specific information on which kinds of contracts need detailed quality assurance plans or information on how to manage a clinical contract rather than a supply contract. In addition, a few CORs stated that the instructors for their training courses had limited knowledge of clinical contracting.

[30]VA requires CORs to complete training courses to obtain the Federal Acquisition Certification (FAC) for CORs or FAC-COR. There are three levels of FAC-COR certifications, which directly correlate with the years of a COR's contracting experience. Specifically, the FAC-COR Level I certification is an 8-hour training and does not require previous experience as a COR, the FAC-COR Level II certification is 40 hours of training (Level I combined with an additional 32 hours of training) and requires 1 year of previous experience serving as a COR, and the FAC-COR Level III certification is 60 hours of training and requires 2 years of previous experience serving as a COR.

We also reviewed the content of VA's 32-hour COR training course administered by the VA Acquisition Academy and found that this course had several limitations in preparing CORs to manage clinical contracts in VA facilities, including the following:[31]

- **Focused on contracts that buy goods, not services**. The primary examples used in the course did not include a discussion of clinical contracts at VA and instead walked students through the contracting process using examples such as replacing carpet and making a large computer equipment purchase. There were no examples focused on how to evaluate or measure the quality of services provided by a contract provider in a VA facility's clinical setting.
- **Included little information on monitoring responsibilities**. The course content included limited information for CORs on post-award monitoring responsibilities for clinical contracts and instead was heavily weighted to discussing the pre-award development of a contract.

To supplement this required course, VA's Medical Sharing Office in June 2013 developed and implemented an 8-hour training course for CORs managing clinical contracts. However, VA did not require this course be completed by all CORs managing clinical contracts.[32] This course covered primarily pre-award contract development responsibilities of CORs and did not include any significant information on the post-award monitoring responsibilities of CORs managing clinical contracts.

In October 2013, we recommended that VA modify its COR training to ensure it includes examples and discussion of how to develop and monitor service contracts—including contracts for the provision of clinical care in VA facilities. VA concurred with this recommendation. In August 2014, VA provided us with a copy of its revised training modules for

[31]See GAO, *Human Capital: A Guide for Assessing Strategic Training and Development Efforts in the Federal Government*, GAO-04-546G (Washington, D.C.: March 2004). We found that well-designed training and development programs are linked to both agency goals and to the organizational, occupational, and individual skills and competencies needed for the agency to perform effectively.

[32]In June 2013, the Chief of the Medical Sharing Office reported that VA had developed a proposal that makes this training course a requirement for all CORs of clinical contracts and submitted it to the Department's labor relations partners for approval. However, there is no target date for completing this review and instituting this requirement.

CORs and notified us the Department intends to require this training for all CORs.

VA's Oversight of VA Facility Clinical Contract Monitoring Is Limited

Our recent work has also found that VA has not established a robust method for overseeing the monitoring of clinical contractors by COs and CORs throughout its health care system. Our October 2013 report found that VA's primary oversight entity for health care contracting activities, the VHA Procurement and Logistics Office, has a limited role in overseeing the monitoring actions of COs and CORs once a contract has been approved and initiated at a VA facility. The VHA Procurement and Logistics Office conducts limited oversight of contracting activities throughout the VA health care system through its SAOs and Procurement Operations Office.[33]

- **Service Area Offices**. According to officials from the three SAOs we interviewed for our October 2013 report, the role of the three SAOs in clinical contract monitoring is limited to an audit of the records COs maintain in VA's electronic Contract Management System. These reviews focus only on the completeness of COs' electronic contracting files—including documentation that a COR with current training records was assigned to the contract. SAO electronic Contract Management System audits did not include any reviews of CORs' monitoring of clinical contractors.
- **Procurement Operations Office**. The VHA Procurement and Logistics Office's Procurement Operations Office is the only entity responsible for overseeing the monitoring activities of CORs; however, the reviews conducted by this office were limited to a remote electronic documentation review of a small sample of COR files.[34] Prior to the release of our October 2013 report, officials from the

[33]In June 2013, officials from the Medical Sharing Office reported that they are beginning to assess whether they can provide oversight to the post-award monitoring of COs and CORs; however, these officials noted that they did not have the necessary staff support to conduct post-award oversight. See GAO, *Internal Control: Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Standards for internal control in the federal government state that agencies should design internal controls that assure ongoing monitoring occurs in the course of normal operations, is continually performed, and is ingrained in agency operations.

[34]Because COR files are not maintained in VA's electronic Contract Management System, the CORs for the contracts selected to be part of these reviews must send copies of their files by email to the Procurement Operations Office staff member conducting the review.

Procurement Operations Office told us that to select COR files for these reviews, a Procurement Operations Office staff member aims to select 25 COR files for active contracts per network contracting office—about 2.1 percent of clinical contracts in an average VISN if all 25 selected COR files are for clinical contracts.[35] VA officials told us that, while the Procurement Operations Office sets a goal to review COR files from two network contracting offices each month, since implementing the program in March 2013 these reviews had been completed in only four network contracting offices and none of these four offices had received feedback on the outcomes of these reviews as of August 2013. These reviews also had a narrow focus on the completeness of COR files because the Procurement Operations Office staff member reviewing the files relies on a checklist to verify the presence or absence of required documentation of COR monitoring activities and does not review the quality of information contained within a COR's records.[36]

We concluded that the limited review schedule and narrow focus on file completeness did not allow the Procurement Operations Office to comprehensively assess the monitoring activities of COs and CORs throughout VA's health care system. Without a robust monitoring system in place, VA cannot be reasonably assured that all CORs in all VA facilities are monitoring clinical contractors and maintaining the proper records of their efforts to monitor the activities of clinical contractors caring for veterans.

We recommended in October 2013 that VA increase its oversight of COs and CORs by ensuring that post-award contracting files are regularly reviewed for all network contracting offices. VA concurred with this recommendation and noted that the Department would revise COR

[35]Officials from the Procurement Operations Office told us that the actual number of files being reviewed has been typically around 21. COR files selected for these electronic documentation reviews may be for any active contract over $250,000 that originates in the network contracting office subject to the review. These contracts can include clinical contracts, supply contracts, construction contracts, and any other type of active contract.

[36]The file reviews assess the presence of documentation in seven key areas: (1) COR training and delegation; (2) the contract and any modifications made to the contract; (3) records of inspections they have completed and any actions taken as a result of these inspections; (4) records of technical and financial reports—including copies of invoices and purchase orders; (5) copies of all required annual contractor performance reviews and security documents; (6) copies of all communications with the contractor and CO; and (7) verification that all contract providers have completed required VHA training.

standard operating procedures to ensure that regular reviews of post-award contract files from all network contracting offices are conducted. While VA has made progress in implementing this recommendation by completing 45 more reviews of COR files in fiscal year 2014 than in fiscal year 2013, these reviews were still only conducted in 5 of the 21 network contracting offices. We believe that to fully implement this recommendation VA needs to ensure that a sample of COR files are reviewed from all network contracting offices.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann, Assistant Director; Jackie Hamilton; Katherine Nicole Laubacher; and Emily Ryan.

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Mr. Christopher K. LaBonte

I, Christopher Kevin LaBonte, had Orthognathic Surgery at the Atlanta Veteran Affairs Medical Center (August 16, 2013) to correct a moderate bite problem that resulted from a lower left mandible fracture that occurred in 2005 while serving in the United States Army. My bite started worsening over time. It became difficult to chew without TMJ pain, and my jaw started to develop limited opening. I was referred to VA Oral Surgeons to correct these problems. The resident medical students with little experience and theoretical knowledge recommended Upper and Lower Orthognathic Surgery as the only course of corrective action. This surgery is the most dangerous and difficult oral surgery performed in the United States. It entails peeling back the face, severing the upper jaw from your nasal cavities, chiseling the lower jaw from the skull, breaking them into pieces, moving the pieces to the desired location then screwing the upper and lower jaw back in with bone plates and screws. The resident students did not describe the surgery in this manner; however, described it as a minimally invasive procedure. One resident stated, "We will make a few breaks and tweak your bite so that it lines up properly. The only risks to this surgery is some minor numbness to your lip and chin area, and infection which is a risk of any surgery."

Considering all of the horror stories about VA surgeries, I requested outside private care to perform surgery with an oral surgeon whom I had an established medical relationship. My Fee Basis (outside care) requests were denied twice. The reasoning stated for denial was my requested surgeon was "too costly, and the VA could perform the surgery at the Atlanta VA Medical Center." I was assured a "world renowned surgeon that has performed this type of surgery hundreds of times" would be conducting the surgery. I would later discover this was an intentionally misleading and untrue statement. The primary surgeon for the surgery was to be an experienced surgeon named Dr. Martin B. Steed, D.D.S. (Doctorate in Dental Surgery). This too was later discovered as misleading and untrue statement made by the VA. The VA resident students stated that if the surgery was not performed my bite would continue to worsen and the jaw opening would diminish to the point where I would not be able to open my mouth. I was informed that I needed to have the surgery now at a young age (age 28 in 2013) so that I would heal properly. The pre-op for the surgery was conducted in July of 2013 by Emory residents, Ibrahim Mohamed Haron (B.D.M.) and Michael Rosenthal (D.M.D.). Rosenthal and Haron were the only residents at my pre-op appointment which concerned me. The VA took special care not to mention Ibrahim Mohamed Haron in the medical notes at this time as he was not licensed at

all. Dr. Steed was not involved in the pre-op appointment which worried me. I was assured by the residents that he was going to review my pre-op appointments notes prior to surgery.

On August 16, 2013, approximately a month and a half after my pre-op appointment, the surgery was performed. I arrived early, as I always do, but was tremendously nervous. I was given medications from the doctors to help relax. I had only seen and talked to residents, so I specifically requested to see Dr. Steed. After about 30 minutes he made an appearance. This reassured me that he was present and would be conducting the surgery. I was then checked into holding where the anesthesiologist administered further medication to relax me.

That is the last thing I remember until waking up in ridiculous unbearable pain and numbness. I, immediately, knew something was very wrong. The surgery lasted longer than anticipated due to complications. I could not speak and was barely able to move my jaw. I was repeatedly told to speak over a period of hours by the resident Ibrahim Mohamed Haron and other medical students that I did not recognize.

I could not speak!

My tongue was numb and my jaw was not moving properly. My nose and mouth was bleeding profusely. The residents were demanding me to speak in an aggressive tone and physically manipulating my jaw while asking me to speak causing extreme pain. I was able to painfully mutter the words "F-ck You" although they could not fully understand what was said. I requested a pen and paper with the best improvised sign language gestures I could muster. I wrote "F-ck You" and underlined it. Then continued to explain that I could not speak and to please stop pulling and pushing on my jaw due to the severe pain it was inflicting. I requested to see my wife multiple times in writing. They denied her access for hours while they forced me to speak.

I stayed overnight for observation in the VA Surgical Intensive Care Unit (SICU). This was a place from a nightmare. I specifically remember another veteran in the room across from me screaming for help in a very desperate voice. His alarm on his machine was going off repeatedly for over an hour. A nurse told him to "hush" or "shut up" multiple times. The SICU was mostly staffed with residents, like most of the Atlanta VA, were laughing, joking, watching movies, taking tests, and completely ignoring this veteran next to me pleading for his life. My wife asked a nurse why this veteran was not being helped and was told to "mind her own business." My own night in the SICU was a long and agonizing night. The nurse set up a

morphine drip with the push button release. The pain was so intense that the morphine was having no affect. The nurse with doctor authorization switched to a diluadid IV pump which had little affect on the pain. The diluadid was able to relax my anxiety, but my pain level was still a 10+. I was released from the SICU the following day, once I was able to urinate on my own.

The VA allowed me to go home. I was ecstatic to get out of the SICU and the VA. I had a white cast material splint around my upper teeth which made it impossible to tell what my upper teeth and jaw looked like. I was given no post-op instructions. Once at home, my nasal cavities began to fill with puss and blood. I attempted to relieve the pressure this caused by blowing my nose. Unfortunately, this ruptured my nasal cavity causing blood and pus to pour out of a hole from stitches that had ripped between my upper gum line and sinuses. My wife called the on-call resident who stated this "was normal and nothing to worry about." Due to the seriousness of the situation, we went to the Atlanta VA Emergency Room which is over 60 miles away from our home. We waited, in the ER, for an on-call oral surgeon to come to the VA. The on-call resident failed to show and we were forced to stay up all night parked in our car in the parking deck for the dental clinic to open in the morning. We saw the resident that we spoke to on the phone the previous day. I did not consider my nasal cavity rupturing normal. My wife and I decided to file a complaint with Elizabeth Cox, a Patient Advocate in the Director's Office. This complaint was not documented in the complaint system as we requested.

I was given elastics to wear by the residents. There were hooks placed on the inside of the splint and hooks on my lower braces brackets for the elastics. My lower jaw was canted at an unnatural angle which was physically and mentally agonizing. The residents told me not to worry that my muscles would adjust with the help of elastics to fix the cant. I could not chew or eat solid food during this period of time. My gums were purple, extremely inflamed, and infected. My face was bruised and enormously swollen. The splint cast came off 6 weeks later. I was alarmed because none of my teeth touched. Again, the residents reassured me that this was normal and the elastics would bring my teeth together.

Three of my incisions were still open and bleeding months after the surgery. My face was still extremely swollen 6 months after the surgery. My lower right side gum line deteriorate due to necrosis from bone shards which were left inside during surgery. Around December of 2013, I could pull back my right cheek and see a large area of bone along with one of the titanium plates. As soon as I noticed the bone and plated exposure, I went to the Atlanta VA and waited all day

to see a resident. They said they could "get in there and see what is going on." Another surgery was then schedule for a month later.

The infection, bone and plate exposure was left unattended and untreated for 4 weeks!

The lower plates and bone shards were finally removed in February of 2014. Once again, my wife and I filed a complaint with Elizabeth Cox regarding having to wait a month to get care for an obvious dental emergency. This complaint was also never put into the complaint system or was deleted at a later time. We also made a complaint to the Assistant Medical Director Robert Evans around the same time. I, unintentionally, bled on Elizabeth Cox's notepad due to uncontrollable bleeding from my nose and mouth. She had to tear off that page and begin her notes again. It was a memorable experience for everyone in the Director's Office, even to this day. My wife also had to speak for me during these complaints because I could not speak clearly.

I had to have all of the plates in my Upper Maxilla removed due to improper placement and infections also in 2014. The plates and screws had been placed on major nerve branches, as well as through my eye sockets. I have lost the majority of supporting bone to my Upper Maxilla due to surgical manipulation, misplacement of surgical hardware, and infections. The Upper Maxilla hardware was removed by an outsourced private practice oral surgeon in back-to-back surgeries starting in October of 2014. This private practice oral surgeon stated that "the way the hardware was installed makes no sense to me."

I did not see Dr. Martin Steed again after I left the SICU on August 17, 2013. He left the State of Georgia a month after my surgery. The new residents that were constantly rotating in and out had no knowledge of the details of my surgery or my care. They had no knowledge of how the elastics were suppose to be worn, why my bite alignment was still not correct, or why my pain had not diminished. There was an all around serious lack of communication. I paged Ibrahim Mohamed Haron at Emory, and expressed my concerns over the phone. He told me, "Your bite should be aligned and you should feel no pain because it has been 4 weeks since your surgery." He then ended the phone conversation. He never made any follow up inquiries into my care or attempted to see how I was doing directly after the surgery.

In 2015, I discovered that **while under anesthesia** the residents had me sign a digital consent pad authorizing Ibrahim Mohamed Haron to be the Primary Surgeon and authorizing procedures not discussed in my pre-op appointment. I do not remember or have any knowledge of signing or reading these documents, especially since I was under anesthesia. I believe I was

coerced into the surgery so that the residents could gain surgical experience on a "real" patient with this specific procedures.

The resident that was the primary surgeon that performed the surgery only had obtained a Bachelors Degree in Dental Medicine from the University of Kuwait. He graduated in 2009. He misrepresented himself as a doctor with a medical background. **This is a felony in the State of Georgia.** He has practiced Dentistry without a license in the State of Georgia, which is also a felony. He obtained his first Dentistry License a week before my surgery from the State of Virginia. Virginia License #0401414186; Date Acquired: 08/09/2013; Expires: 03/31/2016. Later he obtained a License from Illinois by referencing his Virginia License as proof a background. Illinois License #019030033, Date Acquired: 08/28/2014; Expires: 09/30/2015. Ibrahim Mohamed Haron could not prescribe my medication, yet alone Motrin since he has no Doctorate Medical Graduating Degree. He had the technical skills of any Bachelor Degree student; not a Doctorate Degree. I am one of the first people he operated on and the legality of is still in question.

One question to the VA would be why was such an inexperienced surgeon allowed to operate on me? Upper and Lower Orthognathic Jaw Surgery is a very complex and dangerous surgery. Not to be taken lightly. Oral Surgeons with years and years of experience have difficulty with this surgery, but have the experience and knowledge to overcome most of these complications.

Why was my informed consent changed and obtained in an unethical and sneaky way? My informed consent was not obtained as some of the procedures conducted were never discussed or their side effects. If the residents would have mentioned the side effects of worsening of bite, bone death, jaw loss, tooth loss, death from stroke, permanent nerve damage, or Trigeminal Neuralgia during my pre-op appointment; I would not have even considered the surgery to be an option because of these dangerous side effects.

All of these procedures were performed on my upper and lower jaw at one time. As stated before the surgery lasted longer than anticipated. I was in surgery beyond the "normal" timeframe for this surgery. I have been told that I am lucky to have made it through the surgery by several private care doctors. These procedures are incredibly dangerous. I believe my health and well being was not taken into account at all. I honestly believe the primary goal of the VA residents and doctors was to provide a surgery where the residents could gain surgical

experience. I did not knowingly consent to under go surgery with the primary surgeon being Ibrahim Mohamed Haron who was vastly under qualified to perform such an involved procedure on my person.

According to Ibrahim Mohamed Haron's social media pages, he has devote Islamic views. I was an Army combat veteran that was deployed to both Kuwait and Iraq. I was deployed to Kuwait at the same time that Ibrahim Mohamed Haron was attending the University of Kuwait. It is no secret that many people from this region and religion want to harm US Soldiers.

Why was Ibrahim Mohamed Haron allowed to operate on Combat Vets whom he very likely would have had difficultly treating objectively or even had ill intentions towards?

The Department of Veteran Affairs Medical Centers should be sensitive to the need for veterans to feel comfortable and safe with their doctors. The VA Medical Centers, in fact, should be more sensitive to this issue than any other facility in the country. As a combat veteran; I should have been given the choice to have Ibrahim Mohamed Haron involved with my care, on any level, especially performing a highly dangerous surgical procedure that would render me unconscious.

Who investigates these residents' credentials? According to Emory University OMFS Residency program's website, "An applicant must have a D.M.D. or D.D.S. from an American Dental Association (A.D.A.) approved dentistry program/school and licensed in the United States." Ibrahim Mohamed Haron did not meet any of these requirements when he was accepted into the program in July of 2011. Out of thousands of applicants, why was this man chosen if he did not meet the basic requirements of the Emory OMFS residency program? Why did the VA not properly vet his credential either? Ibrahim Mohamed Haron joined the Emory University OMFS program in July 2011 and was acting in an official dental capacity without a license from any state until he obtained his Virginia License in 2013. He did not only practice dentistry illegally at the Atlanta VA, but at Grady Memorial and other local Atlanta hospitals. There is a photo of him, from one of his social media pages, proudly standing on the Grady Memorial Trauma Helipad in scrubs before his Virginia License was granted. He has still not been granted a License from the Georgia Board of Dentistry to practice in Georgia. How is Ibrahim Mohamed Haron, one of Emory's Chief Residents of 2015, not behind bars or deported for committing multiple felonies?

I now suffer many permanent side effects due to the negligence of the Atlanta VAMC, Ibrahim Mohamed Haron, and the doctors assigned to oversee him. I currently have to see many doctors. The periodontist I see every 3 months due to the soft tissue and gum damage sustained from the surgery has stated that my case is the "worst Orthognathic Surgery she has seen." Her sentiments are echoed by my new team of orthodontist who state this is one of the worse cases they have ever seen, and is extremely complicated. A TMJ specialist, who is trying to help me reduce my pain the best way he can, admits my case is very rare and complicated also. I suffer constant chronic muscle spasms from the structural imbalance the surgery created in my facial bones. I have a medical condition called Trigeminal Neuralgia from damage to multiple branches of my Trigeminal Cranial Nerve. Trigeminal Neuralgia, known as Suicide Disease, is described as "one of the most painful medical conditions known to man." It is one of the most sensitive nerves in your body. Your Trigeminal Nerve is how you can tell there is a grain of sand between your teeth. The Trigeminal Nerve is hardwired directly into the pain center of your brain. Having this nerve exposed to open air can cause permanent damage to the nerve. The VA Surgical Report admits to damaging a portion of this nerve (cutting it) during the surgery on August 16, 2013 by Ibrahim Mohamed Haron. I struggle with facial deformity due to the extreme cant of my lower jaw. The pain I experience is a daily constant battle. After over a year of wearing elastics, the doctors have been able to only get one tooth to make contact with my lower teeth. Making one tooth touch at an awkward angle and that is it! All of my bite force is focused on this one tooth and is extremely painful when used to chew. I have to wear an orthodontic splint that allows my upper and lower jaws to make contact artificially. This does help to relieve some of the muscle spasms and strain in my tongue, jaw, and TMJ joints. It also helps me speak properly. According to my doctors, I will have to depend on the use of these and other types of prosthetics for the rest of my life to maintain this small level of functionality. I will have chronic pain, and nerve pain for the rest of my life as well.

There is a surgical option that can try and correct what was done wrong, but due to the many unknowns; such not having full knowledge of what was previously done surgically or the extent of the surgical nerve damage already done; it should be a last resort. As it should have been in the first place. I was told by the residents in October of 2013 that "In a year everything should settle and be mostly healed and the jaws aligned from elastic wear." Well, I waited a year in agony with no improvements, but the opposite. My condition continued to worsen. A recent

Cone Beam CT Scan showed that my Inferior Alveolar Nerve (part of the Trigeminal Branch which the VA admitted to damaging) is exposed. There is a large portion of bone missing in my mandible that usually protects this nerve from external forces and pressure. Every time Masseter and Local Associated Muscles which are used for speaking, eating, drinking, etc., contract and expand in that area of my jaw the nerve is being compressed. This causes intense intractable pain. Multiple portions of my Trigeminal Nerve Branches are also being compressed by hard scar tissue that lines the inside of my cheeks and mouth.

In September of 2014, I decided to file a TORT Claim as I believed gross negligence had been conducted by my "Doctors" at the VA. At this point all of my VA Specialty Care was then outsourced. It has been difficult finding providers that will accept VA Fee Basis payment as it pays lower than Medicare and the payments are never received in a timely manner, if at all. I attempted to get answers from my Local VA Leadership, the Atlanta VAMC Director, and her staff. I was stonewalled and treated like "the enemy" for filing a TORT Claim. My VA doctors were instructed not to speak to me regarding issues or items that had to do with my TORT Claim, which is ridiculous because I still need ongoing medical treatment regarding my jaw. I had to physically point out issues on imaging such as bone loss, nerve exposure, jaw misalignment, etc., to the Clinical Chief of the Dental Department for him to address these issues and record them in the medical records. I was told by the Privacy Officer at the Atlanta VAMC (Paula Marti) that she was not allowed to give out Ibrahim Mohamed Haron's licensing or credential information even by FOIA request which was an overt lie. My wife and I have been banned from the 3rd Floor of the Atlanta VAMC, which is where the Director's Office and the Administration Offices are located, for asking questions regarding my healthcare. I have audio recordings of this incident. I spoke directly to Elizabeth Cox about why she had not documented my complaints. Only to be told she "Would need to check her notes and get back to me." It has been 3 months since I have last spoken to her and made this request, and no follow up from her to me has been made. I also can no longer get her on the phone with me.

The Department of Veteran Affairs' investigative process into medical malpractice is corrupt. The Veteran is required to fill out a form SF-95; Claim for damage, injury, or death. The Veteran's case is assigned to one of the Department of Veteran Affairs' many attorneys. This attorney doubles as the investigator into the Veteran's medical malpractice/negligence case. The investigative attorney is legally immune to all criminal actions that they discover during the

course of their investigation. All aspects of the findings of the investigation are attorney client privilege between the Investigating Attorney and the Department of Veteran Affairs. The Veteran is not allowed to file for damages in federal court until the Department of Veteran Affairs' attorney conducts their "investigation". The Department of Veteran Affairs is given six months for this investigation. Even if the veteran files in Federal Court, after the six month wait period, he/she is not allowed access to the Department Of Veteran Affairs' Investigative Report due to Federal Law. From my personal experience, I feel this six month "investigative" period is used to coach witnesses, manipulate evidence, misplace evidence, take subtle retaliatory measures toward the veteran whom filed legal action against the V.A., and to basically conduct all around damage control before the veteran files for damages or injury in Federal Court. Only the Department of Veteran Affairs has investigative jurisdiction over themselves. If you ask a criminal to investigate themselves, they are most likely in the interest of self preservation going to find themselves innocent of all charges. The Department Of Veteran Affairs also enjoys the protection and representation of the Department of Justice's Attorney General if the veteran's claim reaches federal court. While the veteran is forced to find an attorney that is willing to take on a corrupt Governmental Agency, Hospital, and in many cases a University whom have had six months to coach their doctors and other witnesses before the Federal Court Case. The veteran's attorney, in most cases, is tasked with finding an expert medical witness in a narrow medical specialty field. This witness must also be willing to take on the Department Veteran Affairs Medical System and all expert witnesses the Department of Veteran Affairs Medical System has on their payroll. Furthermore, the veteran's attorney has no access through the process of discovery to the "investigation" the Department of Veteran Affairs' Attorney/Investigator conducted. The Attorney representing the veteran is only entitled to 20% of total damages awarded if settled before federal court. If the veteran's case goes to federal court, the Veteran's Attorney is entitled to 25% of the total damages awarded. All of these legal advantages granted to the Department of Veteran Affairs creates Veteran Affairs Medical Malpractice cases **(Commonly referred to as TORT Claims)** extremely undesirable for an attorneys tasked with representing the veteran. All cards - monetary, legal, and technical are stacked against the already injured veteran who finds himself in the unfortunate situation of taking on an extremely corrupt system by him/herself.

I brought many of the medical and ethical issues described in the above testimony to the

attention of senior management at the Atlanta Veteran Affairs Medical Center. After many attempts and frustration of trying to settle these serious medical quality of care issues locally with management at the Atlanta Veteran Affairs Medical Center, I contacted Secretary McDonald's staff which motivated the local Atlanta Veteran Affairs Medical center to start improving my quality of care. Secretary McDonald contacted me directly and gave instructions to contact him or his staff if I had any other quality of care issues regarding the local Atlanta Veteran Affairs Medical Center. I specifically requested a meeting with the local Atlanta Veteran Affairs Medical Center Director, Leslie Wiggins. An appointment was scheduled, but then canceled repeatedly both before and after I filed my Form SF95. I requested to speak with Leslie Wiggins over the phone, which was denied multiple times. I would get transferred to one of her many staff members who would either be unhelpful or not answer their phones. One of Mrs. Wiggin's staff members, the Risk Management Officer Sonja Reid has repeatedly presented an aggressive attitude toward me over the phone and has been very uncooperative in answering any of my questions regarding quality of care issues that directly impact not only my own healthcare but other veterans as well. Sonja Reid instructed local Atlanta Veteran Affairs Medical Center employees and doctors that they were not allowed to speak to me about anything that could be related or associated with my TORT claim. The issues outlined in my TORT claim tie directly into my current medical care. She was essentially denying me care when ordering my doctors not to speak to me which is illegal. Citing the TORT claim as reasoning for these actions against me. My claim status is currently administrative. It is not yet a federal lawsuit and I have no attorney representing me in this early phase of my TORT claim process. There is no legal or ethical obstacle preventing any Veteran Affairs Employee from speaking with me. I believe employees were instructed not to speak to me to avoid self incrimination for being complicit in criminal activity or to prevent any additional damage to their hospital's reputation by preventing me from gaining any further knowledge into just how horrible their quality of care and lack of oversight truly is.

Many veterans are extremely disappointed in both the quality of care and the lack of leadership at the local Atlanta Veteran Affairs Medical Center. I had an appointment to meet with the Atlanta Veteran Affairs Medical Center Director on March 30, 2015. Not surprising to me it was canceled yet again. In sheer frustration, my wife and I decided to visit the Director's Office on March 30, 2015 anyway. I brought an audio recording device in anticipation of a

negative experience, as all of my previous experiences have been negative. This office is located on the third floor at the local Atlanta VA. Every employee present on the floor that day were under strict instructions not to speak to me under orders from Sonja Reid, Risk Management Officer, and Robert Evans, Assistant Medical Director, citing my TORT claim as reasoning. I specifically asked to speak to a patient advocate to file a complaint regarding this bizarre treatment. Initially this was denied by the Assistant Director Robert Evans. Within 2 minutes of my wife and my arrival to the Director's Office - five to six Veteran Affairs Federal Police Officers were called up to the third floor to escort my wife and I off the floor, again citing the TORT claim as reasoning. After explaining to the Veteran Affairs Federal Police my situation and physically showing them what the Atlanta Veteran Affairs Medical Resident did to my face, the Veteran Affairs Federal Police advocated for me to speak to a patient advocate. Mr. Forbes, a Patient Advocate, agreed he would speak to me. One of the Veteran Affairs Police Officers then told me he was under orders from Robert Evans, Assistant Medical Director, to stand outside the door, requiring the door to stay open as I filed my complaint and to "make sure proper wording was used" in my complaint. The patient advocate seemed just as alarmed as my wife and I with having a Federal Police Officer dictating what wording we can and can not use in our complaint. Then after my complaint was finished being documented by Mr. Forbes, the Federal Police Officer dictating the language of my complaint then sat down to notify my wife and I were banned from the third floor. The Veteran Affairs Federal Police Officer then asked the patient advocate, my wife, and I for our driver's licenses for "His report." The patient advocate, Mr. Forbes, seemed alarmed he was being asked for his driver's license information for taking a complaint from a veteran. If my wife and I ever return to the third floor at the Atlanta Veteran Affairs Medical Center, we will be charged with felony federal trespassing. I have this entire strange event that occurred on March 30, 2015 audio recorded. Georgia is a one party consent state when it comes to audio recording, I was well within my rights. Federal Law is also one party consent. I believe this audio recording helps give context to the hostile environment veterans face daily at the Atlanta Veteran Affairs Medical Center.

I wake up everyday in chronic pain. If you can imagine the worst tooth pain you have ever felt; that is how all of the teeth on the right side of my mandible feel constantly and daily. I have to take muscle relaxers 3 times a day for the muscle spasms. I take narcotic pain medication 4 times a day for the chronic pain, muscoskeletal pain, and nerve pain. I take anxiety medication

to keep my facial muscles from tensing and compressing my nerves which not only cause sharp facial pain, but also causes severe migraines. These migraines feel like someone is kicking me in the skull. My diet is limited to soft foods that do not require much chewing. According to my current team of Non-VA Doctors, I will not only need continual medical care for my mouth and jaw, but I will have to wear oral prosthetics in my mouth for the rest of my life.

I am extremely disappointed in the VA Healthcare System. The VA's priorities seem to be in the following order: 1) Profit; 2) Hospital Reputation; 3) Protecting High Level Bureaucrats; 4) Protecting Negligent Doctors; 5) Cutting Costs at the Expense of Veteran Healthcare; and finally, 6) Veteran Healthcare. I would refer to it is as death-care, as health is barely taken into account. From my experience the Atlanta VA Medical Center's motto should read, "Delay, Deny, and Hope You Die."

Respectfully,
Christopher K LaBonte

Date: 22 May 2015

Evidence that the resident Ibrahim Mohamed Haron was not qualified to be in the Emory University OMFS program. In addition to not being qualified to perform a complex and dangerous Orthognathic Surgery on the OIF veteran, Christopher Kevin LaBonte.

Contact and Application Procedure

Gary F. Bouloux, DDS, MD, MDSc, is our residency program director.

All residency applicants are required to have a DDS or DMD degree from an ADA accredited dental school. Six-year MD integrated track applicants must also have a 3.5 undergraduate GPA. Applications are to be routed to the ADEA Postdoctoral Application Support Service (PASS) by September 17th. Our program also participates in the National Dental Matching Program (MATCH).

While it is not necessary to send applications to our residency office, we do require that applicants send a passport sized photo and an official copy of undergraduate transcripts by October 1st to:

Tracey Hollingshed, tracey.hollingshed@emory.edu, 404.778.4555
Oral and Maxillofacial Surgery Residency Program Coordinator
Emory University School of Medicine
1365 Clifton Road, NE
Suite 2300 B
Atlanta, GA 30322

Image 1: Screenshot from Emory University's webpage describing the basic requirements to be accepted into their OMFS residency program. Applicants are required to have a DMD or DDS from an accredited ADA, American Dental Association, Dental School. There is no evidence to suggest the University of ait Dentistry Program that Ibrahim Mohamed Haron graduated from is American Dental Association Accredited.

Image 2: Screenshot from University of Kuwait's webpage describing their dentistry program and the types of degrees they offer. Doctorate programs were not offered to students until 2010. Ibrahim Mohamed Haron graduated University of Kuwait in 2009 with a Bachelor's in Dental Medicine, not an DMD or DDS.

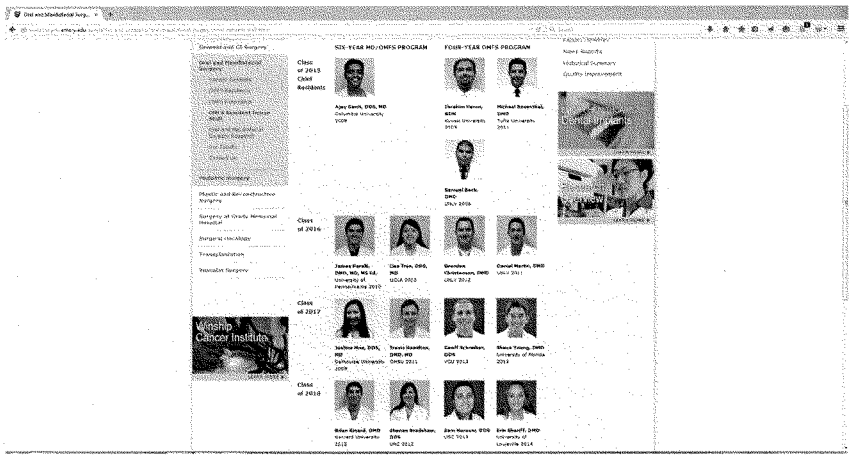
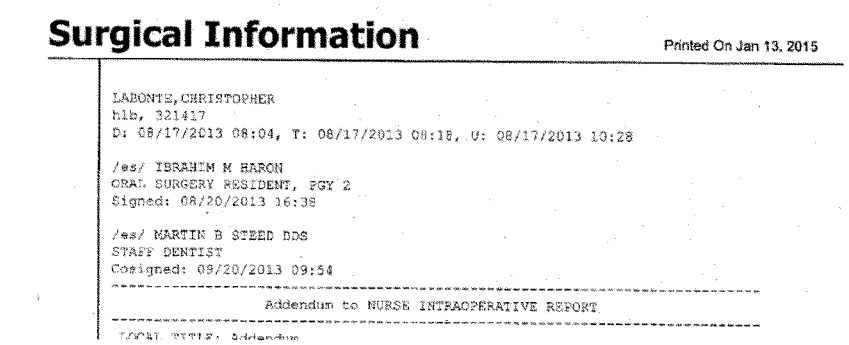


Image 3: Screenshot from Emory's OMFs webpage, take note that everyone on this page has a doctorate with the exception of Ibrahim Mohamed Haron.

irrigated with normal saline and closed with running 3-0 chromic gut suture, after which point the patient's oral cavity was irrigated and debrided. The throat pack was then removed and an OG tube was passed, suctioned and was removed. The patient was turned over to Anesthesia where he was awakened from anesthesia without complication and taken to PACU in stable condition. The patient was then admitted for overnight observation in the ICU.

Dictated by: Ibrahim Haron, D.D.S.

Image 4: Excerpt from Christopher Kevin LaBonte's surgical notes. Ibrahim Mohamed Haron signs the note DDS, a title he did not earn.



Surgical Information

Printed On Jan 13, 2015

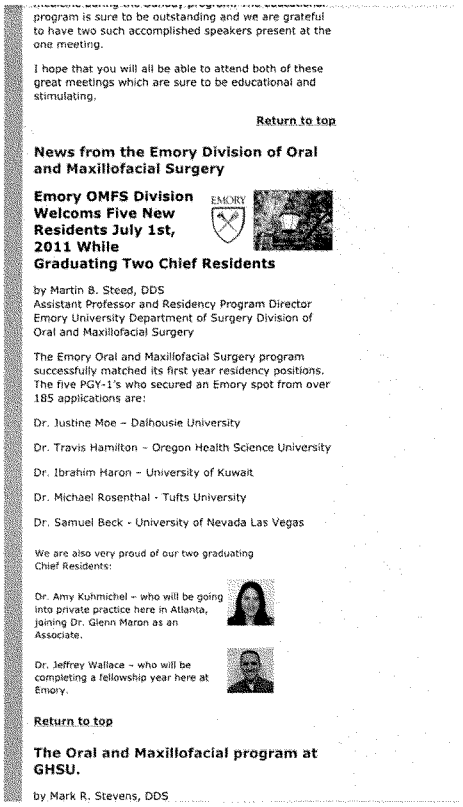
LABONTE,CHRISTOPHER
hlb, 321417
D: 08/17/2013 08:04, T: 08/17/2013 08:18, U: 08/17/2013 10:28

/es/ IBRAHIM M HARON
ORAL SURGERY RESIDENT, PGY 2
Signed: 08/20/2013 16:38

/es/ MARTIN B STEED DDS
STAFF DENTIST
Cosigned: 09/20/2013 09:54

Addendum to NURSE INTRAOPERATIVE REPORT

Image 5: Excerpt from Christopher Kevin LaBonte's surgical notes. Take note that the "dictator" of these notes, Ibrahim Mohamed Haron, signs DDS next to his name at the end of the notes. A title his education level had yet awarded him. This further supports Christopher Kevin LaBonte's statement that Ibrahim Mohamed Haron was misrepresenting himself as a Doctor.



program is sure to be outstanding and we are grateful to have two such accomplished speakers present at the one meeting.

I hope that you will all be able to attend both of these great meetings which are sure to be educational and stimulating.

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News from the Emory Division of Oral and Maxillofacial Surgery

Emory OMFS Division Welcoms Five New Residents July 1st, 2011 While Graduating Two Chief Residents

by Martin B. Steed, DDS
Assistant Professor and Residency Program Director
Emory University Department of Surgery Division of Oral and Maxillofacial Surgery

The Emory Oral and Maxillofacial Surgery program successfully matched its first year residency positions. The five PGY-1's who secured an Emory spot from over 185 applications are:

Dr. Justine Moe – Dalhousie University

Dr. Travis Hamilton – Oregon Health Science University

Dr. Ibrahim Haron – University of Kuwait

Dr. Michael Rosenthal - Tufts University

Dr. Samuel Beck - University of Nevada Las Vegas

We are also very proud of our two graduating Chief Residents:

Dr. Amy Kuhmichel – who will be going into private practice here in Atlanta, joining Dr. Glenn Maron as an Associate.

Dr. Jeffrey Wallace – who will be completing a fellowship year here at Emory.

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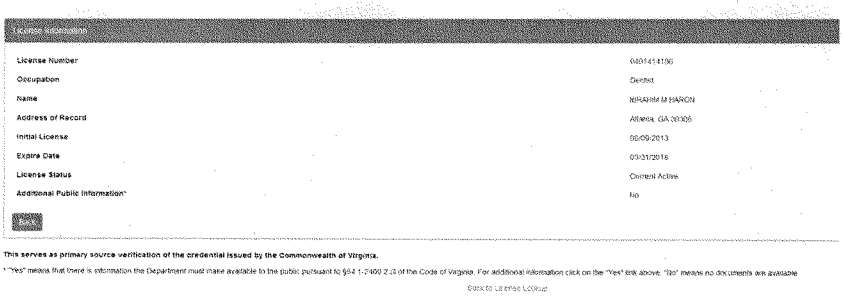
The Oral and Maxillofacial program at GHSU.

by Mark R. Stevens, DDS

Image 6: Screenshot from Emory's news section. Accepting new resident doctors into the program. Specifically mentioning "Dr. Ibrahim Haron." Take note of the date, July 2011.

Image 7: Image from Ibrahim Mohamed Haron's social media, Facebook, page of him proudly standing on the Grady Memorial Helipad in scrubs. Take note of the date August 26, 2012. "Children's Response Air" is written on the side of the helicopter. Ibrahim Mohamed Haron was not licensed to practice any sort of medicine/dentistry at this time.


License Information

License Number	0601414106
Occupation	Dentist
Name	IBRAHIM M HARON
Address of Record	Atlanta, GA 30306
Initial License	08/09/2013
Expire Date	03/31/2016
License Status	Current; Active
Additional Public Information*	No

Back

This serves as primary source verification of the credential issued by the Commonwealth of Virginia.

*"Yes" means that there is information the Department must make available to the public pursuant to §54.1-2400.2.d of the Code of Virginia. For additional information click on the "Yes" link above. "No" means no documents are available.

Back to License Lookup

Image 8: First Official Dentistry License Ibrahim Mohamed Haron obtained. The issue date of this "Initial License" is August 9, 2013. This license was issued in the State of Virginia and is only valid in that state. Christopher K. LaBonte's surgery was August 16, 2013. Christopher K. LaBonte's pre-op was in July of 2013 at which point he was assured Dr. Martin Steed would be the primary surgeon and that the residents were only there to assist. Ibrahim Haron was involved with the pre-op procedures even though he was not licensed anywhere in the United States at that time.

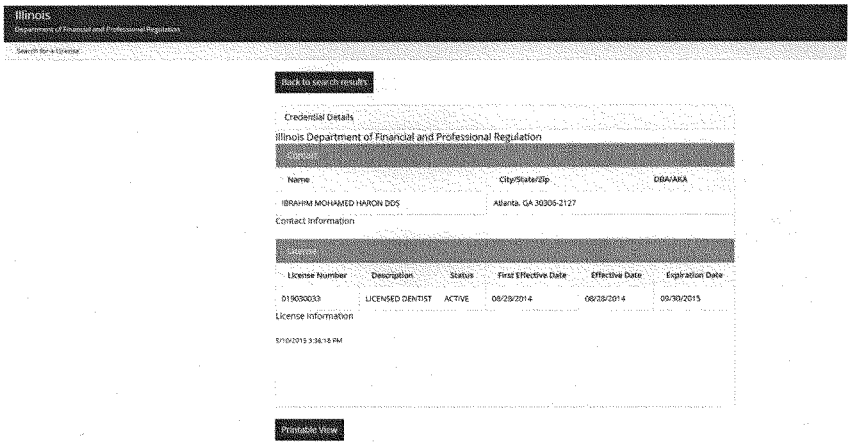
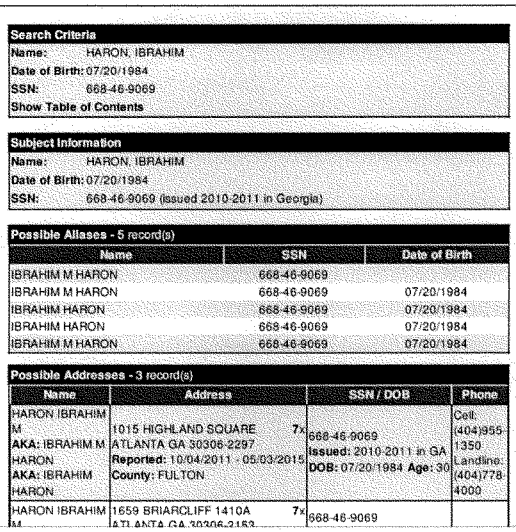


Image 9: Second License Ibrahim Mohamed Haron obtained in the State of Illinois. Issued August 28, 2014. Expires September 30, 2015. It is curious that he would obtain a second out of state license that expires before his already issued Virginia license which expires March 31, 2016.



Search Criteria

Name: HARON, IBRAHIM
Date of Birth: 07/20/1984
SSN: 668-46-9069
Show Table of Contents

Subject Information

Name: HARON, IBRAHIM
Date of Birth: 07/20/1984
SSN: 668-46-9069 (issued 2010-2011 in Georgia)

Possible Aliases - 5 record(s)

Name	SSN	Date of Birth
IBRAHIM M HARON	668-46-9069	
IBRAHIM M HARON	668-46-9069	07/20/1984
IBRAHIM HARON	668-46-9069	07/20/1984
IBRAHIM HARON	668-46-9069	07/20/1984
IBRAHIM M HARON	668-46-9069	07/20/1984

Possible Addresses - 3 record(s)

Name	Address	SSN / DOB	Phone
HARON IBRAHIM M **AKA:** IBRAHIM M HARON **AKA:** IBRAHIM HARON	1015 HIGHLAND SQUARE 7x ATLANTA GA 30306-2297 **Reported:** 10/04/2011 - 05/03/2015 **County:** FULTON	668-46-9069 **Issued:** 2010-2011 in GA **DOB:** 07/20/1984 **Age:** 30	Cell: (404)955-1350 Landline: (404)778-4000
HARON IBRAHIM M	1659 BRIARCLIFF 1410A 7x ATLANTA GA 30306-2153	668-46-9069	

Image 10: Screenshot from Ibrahim Mohamed Haron's investigative profile showing that he obtained his SSN in Georgia between 2010-2011. He is residing in the United States on a Student VISA. It also states that his birth date is 20 July 1984. This man appears to be much older than 30. Which ties into the credentialing issues. How does one properly vet residents from third world countries where identities/degrees can be purchased from public officials for as little as a couple hundred dollars.

Index of Medical Evidence in Support of Christopher Kevin LaBonte's Testimony

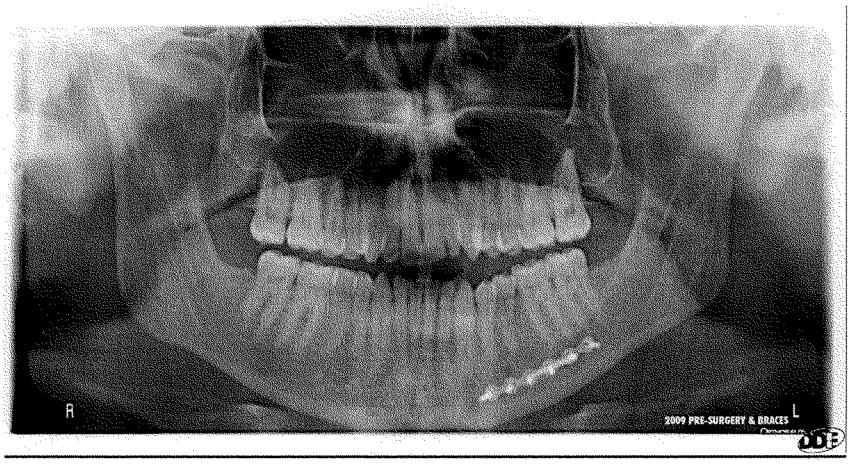


Image 1: Panoramic X-Ray taken in 2009 before braces or any surgical intervention. Note how healthy the jaw and tooth roots look.

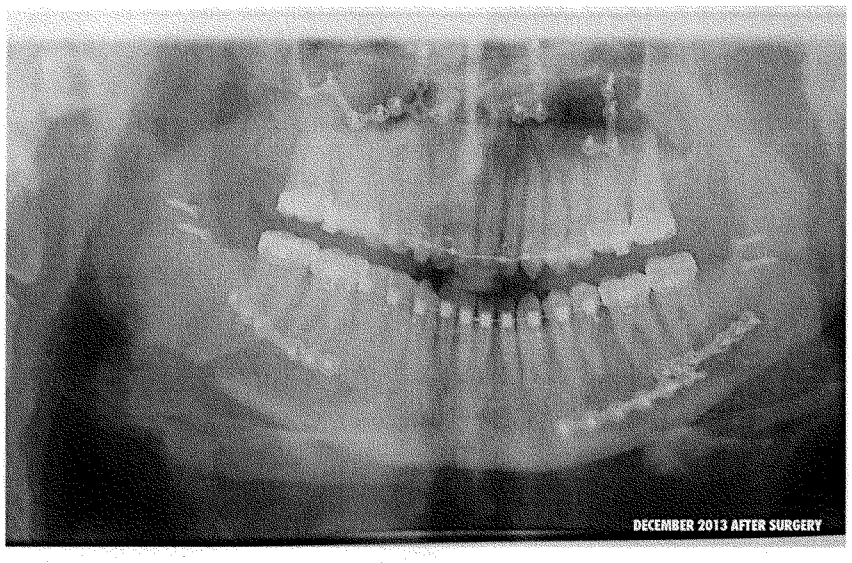


Image 2: Panoramic X-Ray taken in December following the Orthognathic Surgery performed on August 16, 2013. Note the fracture, on the lower left, open (not healing) and the large amount of hardware in both the upper and lower jaw. Mr. LaBonte was not made aware that such a large amount of hardware was going to be used in this surgery or the possible health risks involving this hardware. Increased risk of infection, improper healing, auto-immune system response to foreign bodies which includes a wide range of symptoms, possible nerve compression/damage due to misplacement of hardware, possible bone death due to hardware cutting off blood supply to certain parts of jaw, tooth root damage due to screws from hardware, among many other negative side effects.

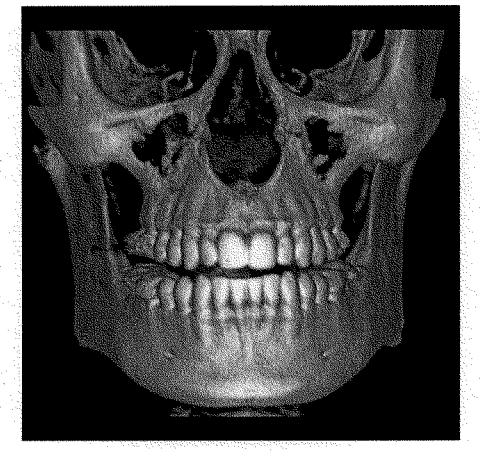


Image 3: A Cone Beam CT (CBCT) scan from a healthy jaw for comparison to the following cone beam CT scans taken after Christopher LaBonte's hardware removal due to improperly placed hardware using poor and inexperienced surgical techniques. The Original CBCT scan from before the surgery has been conveniently "lost" by the Atlanta Department of Veteran Affairs.

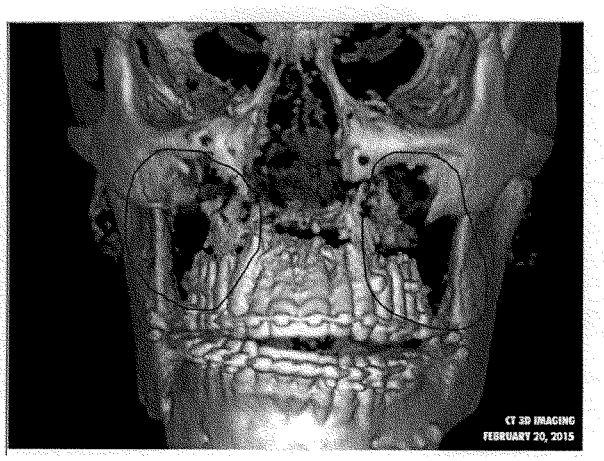


Image 4: Full Volume Frontal View of Christopher Kevin LaBonte's CBCT scan. Note the holes in the eye sockets from screw and hardware removal. Also note the bone loss due to hardware removal due to poor/inexperienced surgical technique.

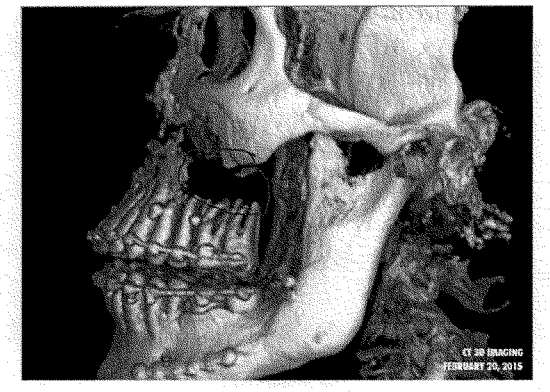


Image 5: Left Side Full Volume CBCT Scan View. Note bone damage and loss due to poor surgical technique and an extremely invasive procedure conducted by an inexperienced/unqualified surgeon.

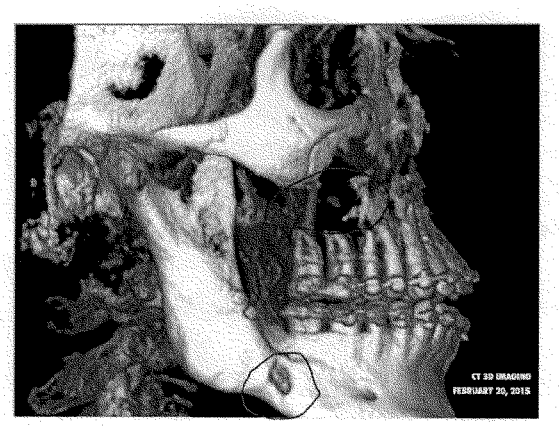


Image 6: Right Side Full Volume CBCT Scan View. Further bone loss and damage. Note the Lower Right Mandible. There is a hole in the bone due to necrosis from bone shards that hardware was placed over. The inferior alveolar nerve that the surgeons admit to damaging on the right side is also exposed. This is extremely painful because when the Masseter Muscles contract or strain; it compresses the already damaged/exposed nerve.

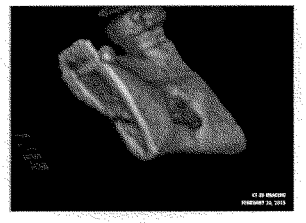


Image 7: Cross Section View of hole in Lower Mandible. Note hairline fracture on the rear section of the mandible. Suggests bone has still not fused properly.

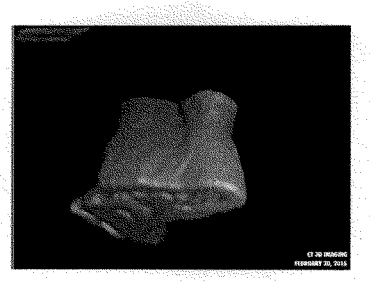


Image 8: Same Cross Section View of Lower Mandible, but at a different angle rotated to show the hairline fracture on the back side of the mandible. Suggests improper healing.

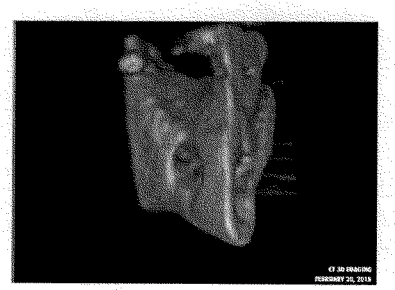


Image 9: Same Cross Section View, but at another angle.

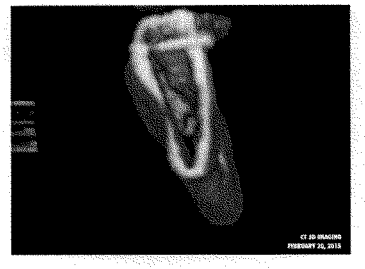


Image 10: Same Cross Section View rotated to see the Internal Mandible Canal. Note the detail in the imaging. You can count the groves on the screw.

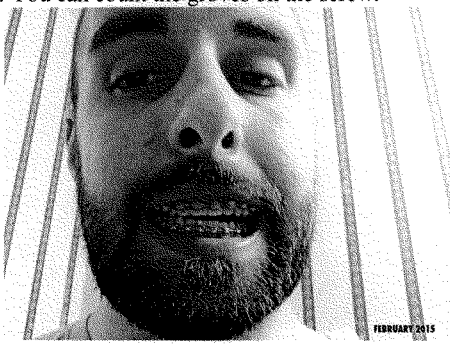


Image 11: Front View of Mr. LaBonte's horrible surgical results. Photo taken in February 2015. Note the extreme malocclusion/jaw misalignment.

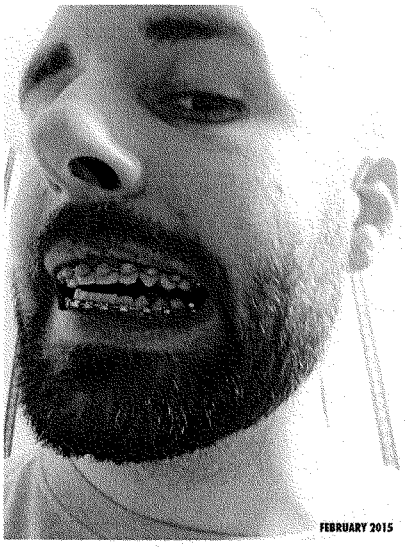


Image 12: Side View of Mr. LaBonte's jaw taken in February 2015. Note the severe open bite, malocclusion, and open bite.

lateral aspect of the proximal segment of the mandible. Once the osteotomy was complete, it was noted that the nerve was free and there was partial injury to the inferior alveolar nerve on the lateral segment. Next, during this time, two 5-0 Prolene sutures were used to reapproximate the partially resected inferior alveolar nerve. Next, the sagittal split osteotomy was then achieved by using the Smith spreader. Next, the area was then cauterized of all

Image 13: Excerpt from Christopher Kevin LaBonte's Medical Records where the dictating surgeon, Ibrahim Mohamed Haron, noted he damaged Mr. LaBonte's Inferior Alveolar Nerve.

Note: *Damage to the Trigeminal Nerve is likely to cause Trigeminal Neuralgia which is described in multiple medical literatures as "One of the most painful medical conditions known to man." Mr. LaBonte has been diagnosed with Trigeminal Neuralgia due to the extensive nerve damage sustained during the surgery on August 16, 2013 at the Atlanta VAMC. Mr. LaBonte also believes medical technical/surgical mistakes were purposefully left out of the surgical notes in order for the surgeons involved to maintain their careers. Mr. LaBonte believes multiple portions of his Trigeminal Branch were damaged, not just his Inferior Alveolar Nerve.*

DELIVERABLE HVAC O&I HEARING TITLED "CIRCUMVENTION OF CONTRACTS IN THE PROVISION OF NON-VA HEALTHCARE"

Congresswoman Walorski's asked a question regarding a constituent vendor who is no longer eligible for a VA contract for orthotics.

VHA Response:

The VISN 11 Prosthetics Integrated Service Line has been working for some time to move vendors to firm contracts that require a standard level of quality from approved vendors. VISN 11's effort is part of a VHA-wide initiative. The goal of the initiative is to:

- Ensure quality patient care to provide a satisfactory Veteran experience;
- Improve timely Veteran care;
- Assure compliance with Medicare prices.

The VISN's seven (7) medical centers and their CBOC's have been relying on purchase card micro-purchases to fill Veteran prosthetics needs for many years. The Prosthetics Integrated Service Line has used firm contracts to ensure quality, timeliness and price for many years on artificial limbs procurements. This initiative closely aligns the Orthotic procurements with the standards already set for Prosthetics artificial limb purchases via historical contracts and Medicare patient guidelines. It also follows the national accrediting bodies' scope of practice for Orthotic-Prosthetics-Pedorthic patient care.

Leather Banana, the vendor mentioned (unnamed) at the hearing, has provided satisfactory Orthotic goods and services in the past to VISN 11. However, Leather Banana is a retail store that sells handbags, wallets, belts, etc. They do not have a certified pedorthist on-site to ensure orthotics are properly fitted and perform in the intended function. Other vendors have been unscrupulous, and provided non-therapeutic shoes in place of diabetic shoes, as one example. This causes a delay in the Veteran's treatment when a new order must be made. Furthermore, the wrong shoe or ill-fitting shoe can lead to an amputation for an at risk Veteran patient.

To be qualified for the advertised contracts, Leather Banana was informed they needed to have a certified Pedorthist on staff. They were unable to meet this requirement even though VHA extended the response date by an additional 30 days at the request of Leather Banana.

The VISN 11 Prosthetics Integrated Service Line decided to create firm contracts with qualified vendors across their region. To be deemed qualified, VISN 11 follows Medicare guidelines for clinical practice, coding and billing. Also, VISN 11 Prosthetics used the national accrediting bodies in Orthotic-Prosthetics-Pedorthic scope of practice for certified clinicians.

VISN 11 Prosthetics decided it was important to allow as many vendors as possible, and manageable, to be eligible to ensure sufficient regional coverage. They selected a minimum quality standard of having a certified Pedorthist on staff. The terms and conditions of the contracts allow VHA to inspect vendor facilities, review patient records, and billing practices to ensure the vendors stay within the scope of practice established under the contract. VISN 11 Prosthetics has a certified Contracting Officer Representative to monitor each contract. Each Veteran patient order will be paid using the purchase card to minimize the time from VHA consult to vendor order. Some responding vendors have offered prices lower than Medicare rates resulting in savings for VHA.