STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"SHAPING THE FUTURE:
CONSOLIDATING AND IMPROVING VA COMMUNITY CARE"
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Mr. Chairman, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work concerning VA's Choice Program and the future of VA's Community Care Program. Our statement covers our work related to issues discussed in VA's *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care* (Consolidation Plan), submitted to Congress as required by Public Law 114-41, Surface Transportation and Veteran Health Care Choice Improvement Act.

BACKGROUND

For years, VA has relied on Non-VA programs to help it carry out its mission of providing medical care, including delivering outpatient services, inpatient care, mental health services, dental services, and nursing home care to veterans via purchased care. Today, VA's purchased care programs include Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. We have reported in our audits, reviews, and healthcare inspections and discussed in hearings the challenges VA faces administering these programs.

In October 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs into VA's Community Care Program. Under consolidation, VA continues to have problems determining eligibility for care, authorizing care, making accurate payments, providing timely payments to providers, and ensuring the continuity of care provided to veterans outside the VA healthcare system. Without improvement in these areas, these issues will continue to be obstacles to ensuring veterans receive timely access to quality care. To increase the program's overall effectiveness, VA and Congress must understand the historical barriers and control weaknesses that have plagued VA's purchase Care programs and ensure they are adequately addressed in future purchased care programs. I would like to highlight our work in:

- Veterans Choice Program
- Financial Accounting of Community Care Funds
- Patient Centered Community Care (PC3) Program
- Non-VA Fee Program

VETERANS CHOICE PROGRAM

We have recently completed audits and reviews concerning the Veterans Choice Program and our findings have substantiated problems with authorizing and scheduling appointments, consult management, network adequacy, and timeliness of payments to providers.[1]

VA initiated the Veterans Choice Program in response to the *Veterans Access, Choice, and Accountability Act of 2014* (VACAA) (P.L. 113-146). Following enactment of VACAA, VA contracted with Health Net Federal Services, Limited Liability Corporation (Health Net) and TriWest Healthcare Alliance Corporation (TriWest), the administrators of the Patient-Centered Community Care (PC3) program, to administer the program including establishing provider networks nation-wide. The Veterans Choice Program allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates or veterans who live more than 40 miles from a VA facility. From November 5, 2014 to December 31, 2016, about 2.1 million appointments were provided to veterans under the Veterans Choice Program. Total program expenditures during that period were over $2.2 billion, of which $2.0 billion (89 percent) was spent for medical care and the remaining $235 million (11 percent) was paid to Health Net and TriWest for program start up and administration costs. An additional $1.7 billion of Choice funding, which was reallocated through the Veteran Health Care Choice Improvement Act of 2015 (Public Law 114-4), was spent on Hepatitis C and Emergency Care in the Community during the same time period.

Our OIG Hotline has received over 700 contacts about the Veterans Choice Program from October 1, 2015 through January 31, 2017. These complaints fall into the following general categories:

- 48% had concerns about appointments and scheduling
- 35% had concerns about referrals, authorizations, or consults
- 12% had concerns about veteran and provider payments
- 5% had concerns about program eligibility or program enrollment.

In February 2017, we published *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in Veterans Integrated Service Network 6* (VISN 6). We assessed the reliability of wait time data and timely access within a VISN. We selected VISN 6 for this audit to determine whether they provided new patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. We reported that veterans who were authorized

[1] *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in Veterans Integrated Service Network 6*, March 2, 2017; *Review of the Implementation of the Veterans Choice Program*, January 30, 2017; *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, October 4, 2016; *Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, FL*, February 5, 2016; *Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, CO*, February 4, 2016

Choice care in VISN 6 did not consistently receive the authorized health care within 30 days as required by Health Net's contract with VA.

We reviewed a statistical sample of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of fiscal year (FY) 2016. Based on our sample results, we estimated that for the approximately 34,200 veterans who were authorized Choice care in VISN 6, approximately 22,500 veterans who received Choice care waited an average of 84 days to get their care through Health Net. We estimated it took VA medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and 42 days for Health Net to provide the service. We identified delays related to authorizations for primary care, mental health care, and specialty care. VHA's Chief Business Officer addressed a potential cause for delay in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment, rather than require the veteran to contact Health Net as was required prior to the change. Our analysis showed that, while still untimely, this change lowered the percentage of veterans who waited more than 5 days for Health Net to create an appointment from 86 percent to 69 percent.

The Under Secretary for Health concurred with our 10 recommendations and provided a responsive action plan and milestones to address the recommendations regarding monitoring controls over scheduling requirements, wait time data, and access to health care and consult management. There were also recommendations to ensure staff used clinically indicated and preferred appointment dates consistently, medical facilities conduct required scheduler audits, and staffing resources are adequate to ensure timely access to health care. The report's recommendations remain open.

We also published in January 2017, *Review of the Implementation of the Veterans Choice Program*. Our objective was to determine whether veterans were experiencing barriers accessing Choice during its first eleven months of implementation ending September 30, 2015. We reviewed monthly reports to identify average wait times for multiple stages of the Choice process, including the authorization of care, scheduling, and the delivery of health care to veterans. We determined several barriers existed in accessing care through Choice, to include cumbersome authorization and scheduling procedures, inadequate provider networks, and potential veteran liability for treatment costs. VHA identified approximately 1.2 million appointments to the Veterans Choice List (VCL) from November 1, 2014, through September 30, 2015, for veterans waiting over 30 days for care at VHA medical facilities. During the same period, about 283,500 Choice authorizations were created for veterans who opted into the program because VHA medical facilities could not provide treatment within 30 days. In total, veterans waited approximately 45 days on average from the time they opted into the program to pursue medical treatment to the time they received care through Choice. We calculated a 13 percent rate of Choice utilization based on the number of Choice appointments that were provided (149,000) compared to the number of veteran appointments that were eligible to receive care (1.2 million) through Choice (as shown on the VCL).

We recommended the Under Secretary for Health streamline procedures for accessing care, develop accurate forecasts of demand for care in the community, reduce providers' administrative burdens, ensure veterans are not liable for authorized care, and ensure provider payments are made in a timely manner. The Under Secretary for Health concurred and provided a responsive action plan and milestones to address our six recommendations. The report's recommendations remain open.

In October 2016, we published *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System* (PVAHCS). We analyzed all open consults at PVAHCS through August 12, 2015, and determined that more than 22,000 individual patients had 34,769 open consults at PVAHCS. This included all categories, statuses, and ages of consults. Of the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. These included consults in a status of pending, active, scheduled, and partial results. In addition, more than 10,000 patients had nearly 12,000 community care consults that exceeded 30 days. Consults for care in the community included traditional non-VA care and Choice.

The Under Secretary for Health and the VISN 22 Director concurred with our 14 recommendations and provided a responsive action plan and milestones to address them. The Under Secretary for Health agreed to update VHA's consult policy. The remaining 13 recommendations were issued to the VISN 22 Director to improve consult management, to follow up with patients who may not have received the requested care and to close consults in accordance with national and local policy. The report's 14 recommendations remain open.

In another report issued in February 2016, *Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, CO*, we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care Services. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days. For 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. As a result, VA staff did not fully use Veterans Choice Program funds to afford Colorado Springs Community Based Outpatient Clinic veterans the opportunity to receive timely care.

The Acting Director of Eastern Colorado Health Care System concurred and provided a responsive action plan and milestones to address our four recommendations. We

recommended that scheduling staff use the correct clinically indicated date or preferred appointment date when scheduling primary care patient appointments, new patients are scheduled timely appointments, eligible veterans are added to the Veterans Choice List, and there are sufficient staff to act on consults. The report's recommendations were closed in September 2016.

We are continuing to provide ongoing oversight of the Choice Program. For example, we will submit as required by VACAA a report after 75 percent of the almost $10 billion dollars appropriated to the Veterans Choice Program is spent or when the program ends in August 2017, whichever occurs first. That project is ongoing. We also plan access to care reviews at other VISNs over time.

FINANCIAL ACCOUNTING FOR COMMUNITY CARE FUNDS

Careful management of funds for purchased care is also important to ensure their availability to pay providers. Our contractor for the audit of VA's consolidated financial statements, CliftonLarsonAllen LLP (CLA), an independent public accounting firm has reported VA purchased care under the Community Care Program as material weaknesses in VA's FYs 2016 and 2015 Financial Statements.

CLA's audit of VA's FY 2016 Financial Statements identified Community Care obligations, reconciliations, and accrued expenses as a material weakness.[2] This audit is an annual requirement of the Chief Financial Officers Act (CFO) of 1990. Key control deficiencies were as follows:

- The manual process for estimating costs of care caused a wide variation in amounts estimated. CLA noted numerous examples of obligations being overstated compared to the actual payments made during testing. VA management performed its own analysis and recorded journal entries in the approximate amount of $1.9 billion to liquidate the overstated Choice obligations and $2.6 billion to liquidate the overstated Fee Basis obligations in VA's general ledger at September 30, 2016.
- VA did not have a centralized and consolidated process to validate or monitor the obligation amounts recorded for Choice or Fee Basis programs. As a result, funds were being held as obligated when they should have been closed out. Furthermore, untimely liquidation of obligations due to patients having other health insurance also contributed to obligations being overstated for the Choice program during FY 2016. VA's Financial Management System (FMS) accrued the entire outstanding balance of an obligation when the end date for the contractual performance period had passed, regardless of whether goods or services were provided at period end. As a result, the overestimation of medical care obligations resulted in an overstatement of accrued expenses at period end. Management performed its own review and recorded journal entries in the amount of $1.1 billion to reverse the Choice accrued expenses in excess of actual needs and $1.9 billon to reverse the Fee Basis over accrued expenses at September 30, 2016.

[2] *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015*, November 15, 2016

- A nationwide consolidated reconciliation for community care authorizations recorded in the Fee-Basis Claim System—exceeding $4.9 billion as of September 30, 2016—was not performed with the amounts recorded in FMS for obligations and disbursements throughout most of the year.

CLA also reported processing and reconciliation issues related to purchased care as a material weakness during its audit of VA's FY 2015 financial statements.[3] CLA increased its focus on purchased care given increased funding and implementation of the Choice Act. CLA reported problems with the cost estimation process and additionally noted the lack of reconciliation between the Fee Basis Claims System used to authorize, process, and pay for non-VA Care and VA's Financial Management System where obligations are recorded.

All of these issues—lack of tools to estimate VA purchased care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling purchased care authorizations to obligations in FMS—makes the accurate and timely management of purchased care funds challenging. In addition, the Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities also were not integrated with VA and VHA CFO responsibilities under the CFO Act of 1990 to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating costs, VA has requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls and sufficient staff trained to monitor accounting, reconciliation, and management information processes to ensure they effectively manage funds appropriated by Congress.

PATIENT-CENTERED COMMUNITY CARE

The PC3 program is a VHA nationwide program that provides eligible veterans access through health care contracts to certain medical and mental health services. The PC3 program is used after the VA medical facility exhausts other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. In September 2013, VA awarded Health Net and TriWest PC3 contracts totaling approximately $5 billion and $4.4 billion, respectively. As noted above, on October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the Veterans Choice Program.

[3] *Audit of VA's Financial Statements for Fiscal Years 2015 and 2014*, November 16, 2015

We published a series of five reports on PC3 in FYs 2015 and 2016.[4] We reported that the PC3 program prior to including the Veterans Choice Program did not achieve its estimated cost savings, provide timely access to care, and did not ensure contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements. In addition, we reported that PC3's inadequate provider network contributed significantly to VA medical facilities' limited use of PC3, and that PC3 contracts were not adequately developed and awarded. A theme that was clear from our work was that VA clinical and support staff were dissatisfied with PC3 in such areas as authorizing care, scheduling appointments, and veterans waiting for care. These are some of the same issues we hear today about the Choice Program.

In September 2016, we published *Review of VA's Award of the PC3 Contracts*, where we determined whether VA's PC3 contracts were adequately developed and awarded. VA awarded the PC3 contracts to provide veterans with a comprehensive, nationwide network of high quality, specialty health care services. The contracts were awarded for an estimated $9.4 billion, with a potential cost to VA of $27 billion. OIG found significant weaknesses in the planning, evaluation, and award of the PC3 contracts. The PC3 contracts were not developed or awarded in accordance with acquisition regulations and VA policy intended to ensure services acquired are based on need and at fair and reasonable prices. The contracting officials solicited proposals from vendors without clearly articulating VA's requirements. Thus, the vendors bidding on the solicitation did not have sufficient information on the type of specialty health care services they would need to provide, where to provide them, and the frequency. Although the contracting officer had the authority to execute these contracts, accountability for ensuring the effective award of these contracts was not vested with a senior executive at VA for the level of oversight for this degree of contract risk. We recommended the Interim Under Secretary for Health revise VA's PC3 cost analyses. Additionally, we recommended the Executive Director, Office of Acquisition, Logistics, and Construction, require contract documents be maintained in the PC3 contract files. The Interim Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction concurred and provided a responsive action plan and milestones to address our report recommendations. The report's four recommendations are still open.

In another OIG report from September 2015, *Review of Patient-Centered Community Care (PC3) Health Record Coordination,* we reported that VHA lacked an effective program for monitoring the performance of their two contractors, Health Net and TriWest. We estimated that only about 32 percent of the PC3 episodes of care had complete clinical documentation provided within the time frame required under the PC3 contracts. This was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation. As a result, we found that VA

[4] *Review of VA's Award of the PC3 Contracts*, September 22, 2016; *Review of Patient-Centered Community Care Health Record Coordination*, September 30, 2015; *Review of Patient-Centered Community Care Provider Network Adequacy*, September 29, 2015; *Review of Alleged Delays in Care Caused by Patient-Centered Community Care Issues*, July 1, 2015 *Review of VA's Patient-Centered Community Care Contracts' Estimated Costs Savings*, April, 28, 2015

lacked adequate visibility and assurance that veterans were provided adequate continuity of care, and VA was at risk of improperly awarding incentive fees or not applying penalty fees. We estimated 20 percent of the documentation was incomplete, and an additional 48 percent was not provided to VA within the timeframe required by the contracts. This delayed the processing of payments and we estimated that from January 1 through September 30, 2014, VA made about $870,000 of improper payments. Additionally, we reviewed 433 episodes of care and identified 3 critical findings related to the providers discovery of malignant colon tissue affecting patients in TriWest's network. We examined each critical finding and did not find contract-required elements annotated in the clinical documentation returned by TriWest's providers, such as the name of the VA medical facility staff member contacted and date and time notified. Without this information and the timely receipt of critical findings, VHA lacked assurance that critical findings were being reported in accordance with the contract's performance standards. The Under Secretary for Health concurred and provided a responsive action plan to address the seven recommendations in our report. We recommended VHA implement a mechanism to verify PC3 contractors' performance, ensure PC3 contractors properly annotate and report critical findings in a timely manner, and impose financial or other remedies when contractors fail to meet requirements. All of the report's recommendations were closed in December 2016.

In our September 2015 *Review of VHA's PC3 Provider Network Adequacy,* we reported that inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA only spent $3.8 million of its $2.8 billion FY 2014 non-VA care budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its non-VA care expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3; the CBO lacked an effective implementation strategy for the roll-out of PC3; and neither VHA nor Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health concurred and provided a responsive action plan and milestones to address the recommendations in our report to strengthen controls over the monitoring of PC3 network adequacy and planning for future complex healthcare initiatives. The report's five recommendations were closed in November 2016.

In our July 2015, *Review of Allegations of Delays in Care Caused by Patient-Centered Community Care (PC3) Issues, we* examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction

with both PC3 contracts had caused the nine VA medical facilities[5] we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling.[6] Health Net and TriWest scheduled appointments without discussing the tentative appointment with the veteran, which VHA refers to as blind scheduling. We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submitted timely authorizations, and Health Net and TriWest scheduled appointments and returned authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. We recommended the then Interim Under Secretary for Health ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements. The Interim Under Secretary for Health concurred and provided a responsive action plan and milestones to address our report recommendations. The report's 10 recommendations were closed in June 2016.

At the request of the U.S. House of Representatives Committee on Appropriations, we reviewed VA's budget submission that stated PC3 contracts would save VA $13 million, respectively, in FYs 2014 and 2015. In April 2015, we published, *Review of PC3 Contracts' Estimated Cost Savings*, which we analyzed disbursed FY 2014 PC3 payments. We reported that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates of contract services by veterans impeded VA from achieving its $13 million PC3 cost saving estimate in FY 2014. Further, VA lacked sufficient price analysis to support its $13 million cost savings estimate. VA also lacked an implementation plan to ensure adequate utilization of PC3. VA had established contractual arrangements that the PC3 contractors would develop adequate provider networks, medical facilities would achieve the desired utilization rates, and the accrued PC3 cost savings for health care services would more than offset the contractors' fees. Flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent utilization rate in FY 2014. Because of the under-utilization of veterans using PC3, we estimated that VA would need a utilization rate between 25 and 50 percent to achieve their $13 million cost saving estimate. The Under Secretary for Health and the Executive Director, Office of Acquisition, Logistics, and Construction, concurred and provided a responsive action plan and milestones to address our report recommendations to revise VA's PC3 cost analyses, address VA's low PC3 utilization rates, and maintain required contract documents in PC3 contract files. The report's three recommendations were closed in March 2016.

[5] Four facilities were serviced by Health Net and located in Denver, CO; Fayetteville, NC; Minneapolis, MN; and Richmond, VA. The remaining five were serviced by TriWest and located in Phoenix, AZ; Portland, OR; Prescott, AZ; Seattle, WA; and Tucson, AZ.

[6] VA prohibits VA medical facilities from scheduling appointments without the discussing details with the veteran. VA commonly refers to this scheduling practice as "blind scheduling".

Non-VA Fee Program

VA can purchase health care service on a fee-for-service or contract bases under Title 38 of the United States Code, Sections 1703, 1725, and 1728, when VA medical facilities cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. We have conducted numerous audits, reviews, and inspections on VA's non-VA Fee program.[7] In October 2016, we published *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, which reported consult management issues at the Phoenix VA Health Care System (PVAHCS). We determined that, as of August 2015, more than 22,000 individual patients had 34,769 open consults at PVAHCS. The total open consults included all categories, statuses, and ages of consults. Open consults included traditional clinical consults within the facility, community care consults, such as non-VA care and Choice, prosthetics consults, and administrative consults. Of all the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. In addition, more than 10,000 patients had nearly 12,000 community care consults exceeding 30 days. We made 14 recommendations, including that the Under Secretary for Health update VHA's consult policy. The remaining 13 recommendations were issued to the VISN 22 Director to improve consult management and to follow up with patients who may not have received the requested care. This included recommendations to develop a routine review of closed consults and documenting consults in accordance with national and local policy. Ten of the 14 recommendations remain open.

CONCLUSION

Our audits, reviews, and inspections have highlighted that VA has had a history of challenges in administering its purchased care programs. Veteran's access to care, proper expenditure of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lacked adequate processes to manage funds and oversee program execution. While purchasing health care services from community providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. We plan to provide significant oversight of VA's Community Care programs over the next 3 years.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee may have.

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[7] *Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, SC,* December 20, 2016; *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, October 4, 2016; *Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC*, August 31, 2015; *Audit of Non-VA Medical Care Claims for Emergency Transportation*, March 2, 2015; *Audit of Selected VHA Non-Institutional Purchased Home Care Services*, September, 30, 2013;*Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds*, January 10, 2013; *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System*, November 8, 2011; *Audit of Non-VA Inpatient Fee Care Program*, August 18, 2010; Review of Outpatient Fee Payments at the VA Pacific Islands Health Care, March 17, 2010; *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, August 3, 2009