March 19, 2015

Secretary McDonald,
I am writing to make you aware of massive violations of acquisition and fiscal laws and regulations, which have and continue to take place in the Department of Veterans Affairs. This correspondence details gross mismanagement by senior VA officials, who intentionally looked the other way, avoided their inherent responsibilities, distorted the truth and/or withheld information to avoid responsibility. The scope of this mismanagement and unlawful acts encompasses billions of dollars appropriated by Congress in support of our veterans. I will also make recommendations that you may consider to get the VA back on track.

INTRODUCTION:

Each of us engaged in the Federal acquisition process has an overriding responsibility to taxpayers. Those of us in acquisition leadership positions must always lead in a manner so as to maintain the public trust, while upholding the integrity of the Federal acquisition and financial systems. Senior Veterans Affairs acquisition officials, such as the VA Chief Acquisition Officer (CAO), Senior Procurement Executive (SPE) and Heads of Contracting Activities (HCAs) have paramount roles. We must work in concert to provide superior support to front-line veteran caregivers, while ensuring all laws and regulations are strictly adhered to.

Over the past five years, some senior VA acquisition and finance officials have willfully violated the public trust while Federal procurement and financial laws were debased. Their overt actions and dereliction of duties combined have resulted in billions of taxpayer dollars being spent without regard to Federal laws and regulations. Their actions and/or inactions have and continue to waste scarce government resources, and make a mockery of Federal laws and the acquisition and finance systems.

I am not aware of a single senior acquisition leader being held accountable for wrongdoing or dereliction in the nine years I've been in my present VA position. This is in spite of numerous OIG reports declaring serious waste, fraud and mismanagement verdicts. Unfortunately, there is much that has not been investigated and reported, as detailed below. How can we hold front-line subordinates accountable if senior leaders are not held accountable for dereliction or malfeasance? I'm sure you are aware of the recent criminal allegations against VA Senior Acquisition Executives Iris Cooper, Wendy McCutcheon and Susan Taylor as published in VA Office of Inspector General reports. All are now departed from VA. Unfortunately Department of Justice declined to prosecute them, so none were held accountable for flagrant violations of Federal statutes.

Lamentably, as detailed below, there have been efforts by some senior VA officials, including members of Office of Acquisition Logistics and Construction, Veterans Health Administration, Office of General Counsel, Office of Inspector General, and

Office of Management, to camouflage and obfuscate wrongdoing. Those few leaders who have demonstrated their opposition and taken responsible actions to underscore violations of laws have been scorned, intimidated and reprised against.

While intentional violations of Federal acquisition and fiscal laws add to the VA's now infamous "corrosive culture" recently cited by the White House, these unlawful acts may potentially result in serious harm or death to America's veterans. When VA procures pharmaceuticals, non-VA health care or medical devices without terms & conditions afforded via written contracts, or by officials without proper authority to enter into contracts, the government forfeits all legal protections afforded by contract law. For instance, pharmaceuticals and medical devices procured without contractual terms & conditions may result in products not meeting efficacy and safety mandates.

Recent revelations of biologics purchased without contracts are prime examples of potential dangers to America's veterans engendered through intentional breaches of laws and regulations. Without contracts, Food and Drug Administration certifications are not a legal requirement, nor are Trade Agreement Act or Made-in-America provisions. Acquired non-VA medical services, sans contract terms & conditions, are devoid of required safety and efficacy outcomes. Unfortunately, the government has little recourse if veterans are harmed by products or services obtained without protection of contract terms & conditions. Separately, each of these breaches of law may endanger the lives of VHA medical recipients. Collectively, I believe they serve to decay the entire VA health-care system.

In addition to violations of law and potential harm to veterans, waste is endemic when contracts are not executed. Doors are flung wide-open for fraud, waste and abuse. For example, by law, prices paid for goods or services subject to contracts can only be determined to be fair-and-reasonable by duly appointed contracting officers. If contracts are not executed as required, no fair-and-reasonable price determination will have been made. I can state without reservation that VA has and continues to waste millions of dollars by paying excessive prices for goods and services due to breaches of Federal laws. I can also state without reservation that billions of dollars have been improperly paid to vendors because contracts were not properly executed, and ratifications were not accomplished in accordance with VA and Federal regulations. I will provide examples below.

In addition, traceability and auditability of public funds spent without regard for established laws and regulations are difficult if not impossible to realize. By statute, the public is required to be informed of all acquisition expenditures above $3000, to help ensure transparency and accountability. This mandated data must be recorded in the Federal Procurement Data System (FPDS), which is accessible by the general public. When contracts are not executed or executed improperly, taxpayers may not be afforded access to data describing these expenditures.

As VA's Senior Procurement Executive, it is my professional opinion the VA has understated its annual acquisition spend at a minimum in the range of $5B each of the past five years, due to our inexcusable failure to acquire a substantial quantity of goods and services in accordance with Federal laws and regulations. Because we have not always properly contracted for good and services, we have not recorded our illegal expenditures in FPDS. Taxpayers have no idea how very sizable portions of VA's Congressional appropriations are being spent, which the law demands. We have effectively "hidden" our illegal transactions from public scrutiny. My estimate above is conservative. In FY15 I certified the Department FPDS spend to OMB at $19B. Our reported FPDS spend may be indeed be understated by as much as $6B - $10B annually.

Also, VA small-business goal accomplishments have been and continue to be vastly overstated. Illegal obligations sans contracts are not posted to FPDS, and are thus not properly included in calculations to determine Federally mandated small-business goals. We have announced each year since 2008 that we have exceeded our directed goals for Veteran-Owned and Service Disabled Veteran-Owned Small Businesses. The stated percentages touted are absolutely false given the immense inaccuracy of denominators used to calculate these annual percentages. Sadly in my opinion, in addition to our illegal acts, we've duped the veteran-owned business community we are required by law to advocate for.

The overarching questions are these: How is it possible the VA procurement and finance systems have been allowed to operate where billions of dollars in goods and services are acquired without contracts as required by Federal law? At the tactical and strategic levels, what fiscal checks & balances are absent that would ensure payments are only made against invoices where funds have been legally obligated? Why are VA senior procurement and finance officials not actively enforcing acquisition and fiscal laws? Why haven't senior officials responsible for well-documented violations of public trust been held accountable? How are laws knowingly breached without Office of General Counsel rendering opinions to the contrary? And finally, how do we transform our present operations to comport with Federal laws and regulations, while continuing to support our veterans?

[Note: There are significant operational changes required in VHA's supply chain and non-VA health care processes to enable compliance, including major transformations involving policy, people, processes, and technology. In case you don't know it, VA's financial system is woefully outdated, and we've previously wasted approximately $500M in two failed attempts to replace it. Given our lack of an integrated finance and logistics IT system, we have no method to perform commitment accounting. We have no method to link obligations with contracts, except with manual entries into the VA contract writing system. We have no method to maintain accurate order, receipt and consumption records on billions of dollars worth of products used on a daily basis in VHA hospitals, and our 900+ medical facilities can only cross-level inventories via phone, fax or email. The VA is operating one of the world's

largest health care systems without a 21st century suite of IT business management processes. Those outdated systems in place are largely left without proper maintenance and are unstable. This deficit has been well known for over a decade, without positive remedial actions by VA senior leaders].

You are probably already pondering how the malfeasance and neglect cited above and detailed more broadly below has escaped the VA "independent" auditors. I will allow you to draw your own conclusions from reading this document. However, it is not supposed to happen this way. The Federal Managers' Financial Integrity Act of 1982, as outlined in OMB Circular A-123 - Management's Responsibility for Internal Control, states management has a fundamental responsibility to develop and maintain effective internal controls. Programs must operate and resources must be used consistent with agency missions, in compliance with laws and regulations, and with minimal potential for waste, fraud and mismanagement.

Further, OMB Circular A-123 requires Agencies and individual Federal Managers to take systematic and proactive measures to (1) develop and implement appropriate, cost-effective internal controls; (2) assess the adequacy of internal controls in Federal programs and operations; (3) separately assess and document internal control over financial reporting; (4) identify needed improvements; (5) take corresponding corrective actions; and (6) report annually on internal control through management assurance statements.

There are many senior leaders responsible for the serious problems outlined in this document. However, the VA Chief Management Officer is the last line of defense with regard to internal controls. Their failure to recognize and report the glaring deficiencies I describe throughout this document is, in my opinion, a significant defect in our strategic governance system. It doesn't take genius nor an auditor to recognize VA internal records are not in equilibrium. For instance, if we report $19B in annual spend via FPDS, and VA financial records reflect dollars obligated for products, services and construction don't closely approximate this amount, then something is seriously awry. This very basic but significant discrepancy should have been examined and explained by the Office of Management. It has been observed for a number of years but simply ignored, almost as if billions of dollars represent a rounding error. There are five career SES members subordinate to the CFO who are aware of these serious issues but have done nothing to mitigate them. In fact, when I recently brought these issues to their attention they were demonstrably unhappy I broached the subject.

I am a voting member of the VA Senior Assessment Team (SAT), Chaired by the VA Deputy CFO. The SAT oversees remediation of programmatic control weaknesses detected through VA's internal control reviews under OMB Circular A-123. In 2014 the SAT voted to raise the reporting threshold for material weaknesses from approximately $400M to $1B. I am convinced this action, sponsored and endorsed by the VA Chief Management Office, is not designed to support improved

governance. In fact, in my opinion it may have been done to disguise potential material weaknesses. In the same meeting wherein the council voted to raise the threshold for material weaknesses, they also voted to drop an inquiry into mismanagement of monies related to purchase of non-VA medical care (Fee Basis Care). This was in spite of my forceful plea to maintain this agenda item, given the billions of dollars in illegal expenditures currently being obligated on non-VA medical care. **[Note: I will describe these ongoing illegal actions related to "non-VA medical care" or "Fee Basis Care" below in detail].**

PERTINENT BACKGROUND AND LANDSCAPE:

I have heard several times since your arrival that you and Deputy Secretary Gibson would prefer not to dwell on what has happened in the past. I appreciate your sentiments and fully understand your intent to focus on the future. However, I don't apologize for relating history. What's past is prologue. I don't feel you can possibly appreciate the corrosive culture that still exists in some elements of VA, unless I provide you this information. You are currently relying heavily on several high-ranking executives to transform the Department into "MyVA." You need to be aware that some of the same executives you are relying on have profoundly engaged in malfeasance and obfuscation.

In addition, unpleasant as it may be, there is much unfinished business related to cleaning up the lawlessness and chaos I am describing in this report. We can't sweep it under the rug. Billions of dollars in illegal purchases must be adjudicated via ratification of unauthorized commitments. As described below, these illegal actions occurred before your arrival and continue. We must take appropriate actions prescribed by Federal fiscal law and the Federal Acquisition Regulation, to document and ratify these illegal acts. Unauthorized payments are being executed daily and must cease. Those responsible must be identified and held accountable. In my opinion, without an honest, sincere effort in righting these wrongdoings, we will never restore proper governance and regain public trust.

The VA CAO, Glenn Haggstrom and myself became aware that Veterans Health Administration was wantonly violating Federal procurement laws with regard to procurement of pharmaceuticals on March 29, 2011. I served then as now, as VA's SPE, and we discovered these facts simultaneously at a meeting on that date. During that meeting I immediately directed VHA cease violating the law. **[NOTE: These illegal activities resulted in hundreds of millions of dollars in illegal pharmaceutical purchases across multiple years. Given no investigation was ever conducted, total dollar amounts are impossible to calculate and they could well constitute over a billion dollars].** The CAO instantly undermined me, and would not allow my directive to stand. From that date until August 2012, he provided no support to me whatsoever in my efforts to stop the VA from illegally procuring pharmaceuticals. In fact, he blatantly disregarded his fiduciary responsibilities and impeded my efforts as the SPE to enforce public law. In

addition, I allege he and others intentionally withheld information concerning these unlawful acts from the VA Secretary, which I will detail below.

The Department CAO's responsibilities are statutorily derived and unambiguously defined. The CAO's overarching purpose is to advise and assist the Secretary, who serves as VA's Head of the Agency (HA) in all matters pertaining to acquisition. As enumerated in the Services Acquisition Reform Act of 2003, the CAO's duties include but are not limited to the following responsibilities:

1. Monitor the performance of acquisition activities and acquisition programs of the Agency;
2. Evaluate the performance of those programs on the basis of applicable performance measurements; and,
3. Make acquisition decisions consistent with applicable laws, and establish clear lines of authority, accountability, and responsibility for acquisition decision-making.

I have purposely emphasized the underlined portion directly above. Because the CAO would not support me with regard to cessation of unlawful pharmaceutical purchases, I met with other VA senior officials above and parallel to him, reporting these unlawful acts and requesting their assistance. These officials included Senior VHA officials, the former CFO, senior members of the CFO staff, the VA Chief of Staff, as well as two senior members of the Chief's personal staff. All elected not to act. I concluded they did not act in an effort to shield the Administration from potentially embarrassing disclosures of unlawful acts.

I also reported violations to the Office of Inspector General on more than one occasion. The OIG declined to act as well. As a former Army Inspector General, I found this incomprehensible. **[NOTE: I did not file a formal written complaint with the VA OIG because I did not trust they would maintain my confidentiality. As it turned out, The VA Chief of Staff later contacted the OIG and my boss, actively attempting to find out if I had made a formal OIG complaint. They told him I had not, instead of refusing to answer his inquiry, which was their duty. Much to my dismay, Mr. Haggstrom asked me point blank in writing, in response to Mr. Gingrich's inquiry, if I had filed a formal complaint with the OIG. Inquiries as to whether I filed OIG complaints by both of these senior leaders are blatantly illegal, and support my earlier decision not to file a written OIG complaint].**

I maintained comprehensive notes during this entire time period, and developed a compendium of these notes with attached documents to substantiate my position. My purpose was to prepare myself for a formal investigation, which I believed would surely ensue **[NOTE: the Secretary informed Congressman Joe Donnelly in a letter dated December 20, 2011 that a VAOIG review would be conducted and provided to Congress. I was never questioned. None of my staff involved in these matters were questioned. No comprehensive investigation was ever conducted in spite of Secretary Shinseki's assurances to Congress].**

Throughout this period, the CAO failed to fulfill his fiduciary responsibilities. His repudiation of Federal laws, willingness to look the other way for political expediency, and his complicity with VA and VHA senior leaders (including VA Chief of Staff, VHA Under Secretary for Health, VHA Deputy Under Secretary for Health for Operations and Management, VHA Assistant Deputy Under Secretary for Health Administrative Operations, and VHA's Chief Procurement Officer are clear evidence in my mind of serious lapses in his professional judgment as CAO. I don't make these allegations lightly, and have extensive documentation to support my assertions.

Because I could not get those above me to assist in cessation of these illegal matters, nor gain support from the VA Office of Inspector General, I determined my only choice was to seek assistance from Congress. As a result, I arranged a meeting with Representative Joe Donnelly, then a member of the House Veterans Affairs Committee (HVAC) **[NOTE: Mr. Donnelly has subsequently been elected as a member of the Senate].** I met with him one evening late in October 2011 at his Washington, D.C. residence, along with several members of his legislative staff. He immediately took substantial and forceful actions based on my disclosures. He began by sending Secretary Shinseki a letter dated October 28, 2011 requesting specific information on the Pharmacy Prime Vendor (PPV) program. Congressional hearings were held in January and February 2012 on these matters due to Mr. Donnelly's personal intervention.

The Secretary assured Congress that VA's lawless actions in these matters ceased. In a December 20, 2011 response to Rep. Donnelly's letter, Secretary Shinseki stated, "as of November 10, 2011, VA no longer permits open market purchases through the pharmacy prime vendor (PPV) contract." In other words, the Secretary informed Rep. Donnelly that VA's illegal activity with regards to procurement of pharmaceuticals without contracts had ended.

I believe Secretary Shinseki unknowingly misinformed Congress in his December 20, 2011 letter cited above. In fact, VHA continued their unlawful procurements, amassing 9700 illegal actions valued at approximately $4M between November 2011 and August 2012 **[NOTE: These were self-reported by VHA, and the actual number of illegal actions may be far greater].** I continued reporting this lawlessness to my contacts in the HVAC. The VA CAO, as well as other senior VA and VHA Officials also knew unlawful acts were occurring, but none of them disclosed these violations to the Secretary.

The CAO did nothing in his role to force cessation of illegal activities, or hold those accountable who violated the law. Worse in my view, he and other VHA senior leaders conspired to withhold this information from Secretary Shinseki. This deliberate deception continued throughout, and is reflected at its latest in a December 19, 2013 report signed by each of these senior officials to Secretary Shinseki, reflecting there were no illegal activities. Secretary Shinseki was duped, as no unauthorized commitments were reported as having occurred in the PPV

program after December 20, 2011. Notably, although I am the VA Senior Procurement Executive, I was not a signatory to this major report on the state-of-procurement in VA. I can think of no other reason I was not asked to sign the report except for the fact it contained false information, which I would have utterly renounced, thereby forcing the revelation of these illegal activities.

Several VA senior officials, who testified during the January and February 2012 pharmaceutical hearings referred to above, knowingly deceived the HVAC while under oath. For instance, hearing testimony by VA's senior official, Deputy Secretary Gould, reflects those complicit in the illegal matters had retired or moved on, and thus nobody could be held accountable. This was a false statement. There had been no investigation of the matters in question. In fact, one of the Senior Executives sitting at the witness table had been responsible for the VHA pharmaceutical program for many years. This same Senior Executive testified he had just recently learned of the illegal activities. His testimony was deceptive. I have documents in my possession irrefutably demonstrating he was aware of the illegal acts on May 28, 2009. Additionally, he had briefed myself and the VA CAO on March 29, 2011, wherein he stated he knew these activities had been underway "for at least 15 years" prior.

As previously stated, no appropriate investigation was ever conducted into these matters. No persons were held accountable for these violations of law. The matters were simply swept under the rug, and senior VA leadership directed my office to approve an "institutional ratification" for thousands of unauthorized commitments worth hundreds of millions of dollars. Public trust and accountability for Federal laws and the acquisition system were thrown-to-the-wind in favor of political expediency. The fact nobody was held accountable resounded throughout the Department, and I believe gave succor to those who chose to continue violating laws, which I have detailed below.

[NOTE: I was not uninitiated in having to take extraordinary actions to move the Department into compliance with procurement and fiscal law. In 2010, I learned the Department was continuing to purchase products and services without contracts, using "miscellaneous obligations" in lieu of contracts. Because I was unable to convince senior officials, including my supervisor, that it is illegal to purchase without contracts, I sought assistance from the House Veterans Affairs Committee. I met with a senior HVAC staff member, outlining my concerns and recommendations. I received extraordinary support from Rep. Steve Buyer in these matters. HVAC hearings led to major changes in VA processes with regard to miscellaneous obligations. Unfortunately, illegal activities are still taking place with regards to miscellaneous obligations, as I learned during a February 2015 visit to a major VHA medical center].

In spite of assurances by Congress that it would not happen, the details of my whistleblowing with regard to pharmaceuticals were spread extensively. There is

no question in my mind that members of Congress or their staffs reported my whistleblower activities to VA senior leaders before the hearings convened. In fact my whistleblower actions were so well known that a senior staff member of the Senate Veterans Affairs Committee told me he had been informed prior, and humorously related he attended the hearings to "observe the debacle."

Congress subpoenaed thousands of documents related to these matters from myself and six other VA SES members. In this process I was forced to provide all pertinent documents to the VA Assistant Secretary for Public and Intergovernmental Affairs. These included my comprehensive written notes concerning sensitive matters that only an independent investigatory body should have been privy to. This Assistant Secretary, working on behalf of Secretary Shinseki, was able to see each and every document before they were passed on to the VA Chief of Staff, Deputy Secretary, Secretary, and subsequently to Congress. It was truly a witch-hunt, and in my opinion, a prohibited personnel practice aimed at a whistleblower. Through this process I was identified conclusively as the whistleblower to the very leadership who refused to support me in my endeavors to uphold public law.

Secretary Shinseki had staunchly refused to support me in my actions to bring the Department into compliance with the law regarding illegal pharmaceutical purchases. During a meeting with the Secretary and other senior officials on December 15, 2011, Secretary Shinseki forcefully attempted to gain my concurrence with his declaration that purchasing without Federal contacts was "improper" versus "illegal." I was the lone official in the room who refused to agree with him. He became very angry with me and ordered me to shut up while explaining to him why our actions were illegal. He stated he wanted to hear no more from me. In the same meeting, Mr. Haggstrom very forcefully and unprofessionally attempted to coerce me into telling the Secretary what he wanted to hear.

Representatives from the Office of General Counsel (OGC), also present in the above meeting, gave the Secretary what I considered to be extremely misguided legal advice in this matter. It was OGC who encouraged him to declare our illegal actions to be "improper." The senior OGC member in attendance had previously told me it was "counsel's mission to protect the Secretary and the Department." Her advice to the Secretary reflected her previously stated opinion. I steadfastly maintained we committed illegal acts and it was our duty to protect the taxpayers, not the administration. During subsequent HVAC hearings on these matters, Congressional members overwhelmingly vindicated my position.

I will not comment on the former Secretary's integrity. However, on that particular day, and in that particular moment, I believe he sent a clear message to everyone in attendance. The central message was compliance with Federal laws and regulations in VA was not required, and if and when revelations of improper activity emerged, obfuscation was an option. Recent VA scandals regarding veterans' access to care strongly corroborate my position.

In March 2013, due to continuing revelations of unlawful acquisition activities and after receiving absolutely no assistance from the CAO in effecting their cessation, I recognized the need to seek outside assistance. I decided to notify the VA OIG, although I had misgivings about doing so. My misgivings were due to their previous reluctance to investigate illegal activities I had referred to them regarding pharmaceuticals, as indicated on page six of this report. On March 4, 2013, I forwarded a written hotline complaint to the OIG. A Senior Executive in OIG responded to my complaint with scorn. That official phoned me, questioning my motive for submitting the hotline. Her drift was that I had a "hidden agenda."

I was infuriated by the OIG's response. As a former U.S. Army Inspector General, I understand the roles and responsibilities of Inspectors General, and the response I received from the OIG to my hotline complaint was clearly perpendicular to the oath of impartiality Inspectors General swear to uphold. On April 2, 2013 I wrote a follow-on note of concern to a different Senior Executive in OIG, expressing my displeasure. I informed her I would not be second-guessed by the OIG, and would not be derailed in my pursuit of accountability. On April 10, 2013 I received a reply from the OIG, stating they had opened a case based on their review of information I submitted. I do not know if they ever pursued an investigation, but I assume they did not, as I was never interviewed.

At that point I knew I would receive no assistance from my supervisor, Mr. Haggstrom. It was also obvious neither the VA Secretary nor his senior staff would assist. They appeared only to be interested in covering up violations of public trust. I also could not trust members of the House Veterans Affairs Committee to assist, given they had previously revealed my role as the whistle blower regarding illegal VA pharmaceutical purchases, as detailed above.

I believed I had exhausted my options for assistance in bringing to cessation the illegal matters I had observed. As such, I wrote a letter of concern to the Chairman, House Committee on Oversight and Government Reform on June 2013 **(Attach A)**. At the recommendation of a trusted former Office of Management and Budget (OMB) acquisition official with whom I sought counsel, I hand-carried this letter to the Rayburn House Office Building.

I met with Mr. Rich Beutel and a female colleague of his. Mr. Beutel was then a Senior Counsel on the House Committee on Oversight and Government Reform. In my letter, I outlined my concerns to Chairman Issa. My concerns included the fact that in addition to no one being held accountable for violations of law with regard to pharmaceuticals, VA continued to grossly violate procurement and fiscal laws in other arenas. These included millions of dollars obligated above the micro-purchase level by government purchase cardholders without required contracts. It also included my concerns that millions of dollars worth of prosthetic devices were being purchased without contracts, and that billions of dollars worth of non-VA health care were being purchased without regard for existing laws. I requested his

assistance in bringing these unlawful activities to the attention of the Committee, in an effort to effect their termination.

My letter never made it to Chairman Issa as I intended. Mr. Beutel apparently made the unilateral decision not to advance the letter beyond his level. As I later learned, his reason may have been calculated. I subsequently discovered Mr. Beutel is a friend of Mr. Norbert Doyle, VHA's Chief Procurement Officer and HCA. I learned they had previously worked closely together on a Department of Defense Commission several years earlier. Perhaps due to their friendship, Mr. Beutel collaborated with Mr. Doyle to keep the information out of Chairman Issa's hands. The information was potentially very detrimental to Mr. Doyle and VHA. A few weeks after I submitted the letter and supporting documentation, I called Mr. Beutel to inquire about progress regarding the proceedings. Mr. Beutel was blunt, telling me he had "more pressing issues to pursue." I thanked him and told him I would drop by his office after work and pick up my package of supporting documents. When I picked up the package, it included an email Mr. Beutel undoubtedly never intended for me to see **(Attach B)**.

I was dumbstruck by Messrs. Beutel and Doyle's behavior, but even more so with Mr. Beutel. I entrusted him, a senior staff member on the House Oversight Committee, and he betrayed not only my trust, but also the trust of the American public. He violated his duty of impartiality by conspiring with his friend Mr. Doyle to keep my legitimate pleas for assistance from a member of Congress. The fact he inappropriately handled my documentation of improprieties, and improperly allowed my confidential documents to be perused (and perhaps photo copied and distributed) by Mr. Doyle is beyond the pale. His email note to Mr. Doyle, wherein he thanked him for "taking immediate steps to preserve Committee confidentiality" is incongruous. The only confidentiality he appeared to be concerned about preserving was his own in this illicit conspiracy, as well as concealing his dereliction of duties. Had he been concerned about "Committee confidentiality" he would not have shared my letter with his comrade Mr. Doyle. He certainly didn't preserve my confidentiality, as was his obligation. To confess he violated the covenants of his Congressional position in a written admission is flabbergasting, given the fact he is a trained attorney.

Mr. Beutel's underhanded deeds were subsequently compounded against me many times over. I am categorically convinced Mr. Doyle spread the word of my whistle blowing actions to his superiors and mine at VA. Suffice it to say Messrs. Beutel and Doyle's corruption have and continue to make it very unpleasant for me following my unsuccessful, duty-bound attempts to bring VA in compliance with Federal laws.

CONTINUING MALFEASANCE:

I relate the instances above to set the stage below. The lawlessness and malfeasance have persisted unceasingly since my failed attempt to bring it to the attention of Chairman Issa in June 2013. Below is the history and update on each of the items I

attempted and failed to report to Congress. They are not consistently arranged in chronological order:

Non-VA Healthcare Unauthorized Commitments: On July 11, 2014, I was directed to attend a meeting regarding veterans' access to care. The VA Chief-of-Staff, Joe Riojas, headed the meeting. There were many senior VA personnel at the meeting, including Dr. Jim Tuchschmidt, Phil Matkovsky, Dr. Carolyn Clancy, Lisa Thomas, Tammy Kennedy, Richard Hipolit, Phillipa Anderson, Helen Tierney, Ed Murray, and Ford Heard. Mr. Rob Nabors, a senior White House advisor, also attended the latter portion of the meeting. The entire two-hour meeting centered on access to veterans health care, and specifically the obligation of funds related to non-VA health care (commonly referred to as "Fee Basis Care" or "Fee Care").

The meeting became extremely unpleasant for me almost instantly. VHA leaders advanced a scheme wherein it was proposed I would sign a waiver as the VA Senior Procurement Executive, allowing up to 4000 unqualified persons to sign contracts for "Fee Basis Care." VA's Office of General Counsel also sponsored and supported the plan. It appeared Mr. Heard and I were the only persons in the room opposed to this scheme, which had apparently been concocted before this meeting without my knowledge. I spent two of the most miserable hours of my professional career countering their points, resisting their coercion, and arguing my positions on the matter.

Their plan was illegal; plain and simple. I pointed this out from the start, but that didn't' keep them from applying intense pressure on me to concur and get on with it. I was literally ganged up on by VHA, OGC and the VA Chief Financial Officer, and threatened implicitly during the meeting by the VA Chief-of-Staff. I forcefully argued their scheme would violate existing law. I contended their scheme would be an extension of unlawful acts conducted by VHA for many years in their administration of Fee Basis Care, and was not a viable solution to the problem. Twice during the meeting I asked Mr. Riojas why he desired to perpetuate VA's lawless ways through the scheme presented by VHA and OGC. Both times he directed me to address my questions to a senior OGC member at the meeting, declaring she was in charge. His reply was perplexing, as in my experience counsel is never in charge of programs. Counsel's purpose is to provide legal advice only.

Throughout the course of the meeting, I pointed out VHA had been violating the law for many years, and current and past senior leaders knew of this malfeasance. I stated the former VA Secretary, Mr. Shinseki, had been briefed in May 2013 regarding this matter, remarking I had not been invited to the meeting by VHA for obvious reasons. I denounced both VHA and OGC personnel for these massive and continuous violations of law and for taking no positive actions to stop the illegal behavior. I inquired several times as to what caused their epiphany…. their sudden insistence late on a Friday afternoon the law must now be observed, given they had blatantly ignored my appeals for earlier compliance. The OGC responded that Department of Justice had recently ruled the VA must consider all Fee Basis Care

actions as being FAR-based, and that was the reason for utmost urgency. **[NOTE: In fact I had written an email to Messrs. Haggstrom, Schoenhard, Matkovsky, Doyle and Ms. Anderson over a year earlier in January 2013 requesting they assist me in moving forward to bring us within Federal law for Fee Basis Care contracting. Neither my supervisor, Mr. Haggstrom, nor any of the others included on the message responded in any way to my appeal for assistance].**

I simply could not comprehend their urgency in demanding my immediate concurrence with their nefarious scheme. They had not so much as even acquainted me with their scheme prior to the meeting. Now they were essentially presenting me a *fait accompli*, demanding I concur with a plan in which I positively believed violated Federal procurement laws. I persistently and forcefully refuted their plan. Twice, the Chief-of-Staff threatened me, telling me because of my intransigence, he would be forced to call the Secretary and tell him "Fee Basis Care to veterans must end immediately, and we will not be able to care for veterans." His intent was clear. He was attempting to intimidate me to make a decision that was illegal and irrational. I considered his remarks extremely coercive and unmitigated bullying, and I told the entire assemblage as much more than once. I also remarked twice that this was further example of the "corrosive culture" recently cited by Mr. Nabors in the VA access-to-care scandal White House report.

At one point, the discussion became so sufficiently heated that White House senior advisor, Mr. Rob Nabors, was summoned into the meeting. He listened to the contrasting arguments from others and myself, and essentially agreed with me. His stated opinion was that even if I agreed with the instant scheme, signing a waiver that very afternoon, VHA would be in breach of law for many months or perhaps years, given the significant amount of time needed to develop and implement the proposed new processes, which would include the OMB rule-making process. The end-of-meeting conclusion was that a solution, or proposed way ahead, could wait until the following Monday.

We began crafting a solution the following Monday. Nine months later, nothing has been altered in the process. Illegal activity continues unabated. The representations and proposals provided by OGC to "fix" the illegal behavior in the July 11, 2014 meeting proved to be largely frivolous upon further examination. In fact, the senior OGC official inciting me to agree with their scheme on Friday, July 11, reversed her position nearly 180 degrees the following Monday. Her turnabout nullified almost everything she had previously confidently cited as legally defensible on July 11.

Demonstrating how truly onerous and manifold this task actually was, we worked collaboratively for over four months following the July 11, 2014 meeting, developing a viable solution. However, VHA's Phil Matkovsky thereupon summarily rejected the collaborative solution, in spite of the fact his senior subordinate co-led the integrated process team. While the result met all elements of Federal law, he contemptuously rejected it stating it did not "go far enough" in his opinion. It was

clear in my mind Mr. Matkovsky had no interest in conforming to Federal law. He wanted it the way he wanted it, and the law be damned.

[NOTE: Congressional HVAC hearings were held in July 2008 and again in July 2010, with considerable examination of inadequate internal controls over fiscal matters at VA. During these hearings, there was much discussion of Fee Basis Care as it relates to miscellaneous obligations. At that time within VA, Fee Basis Care was declared to be outside the FAR. This declaration was made by the Assistant Secretary for Management in 2008, in the days leading up to the July 2008 hearings, and done so in his role as the VA Chief Acquisition Officer. OCG supported his decision. I did not agree with his interpretation and told the CAO as much. Given the fact governance of Fee Basis Care is defined and administered under the VA Acquisition Regulation (VAAR), which is the VA supplement to the FAR, in my view there is no plausible way to interpret the administration of this program to be outside of the FAR. It is my opinion this 2008 CAO interpretation was hastily crafted and declared in an attempt to avoid the ire of Congress. Had the HVAC been informed we were violating Federal law, administering Fee Basis Care without required Federal contracts, Congress would have reacted in a very negative way. Thus, in my opinion, the CAO simply declared them not subject to the FAR to avoid potential wrath. A follow-on hearing was conducted on July 28, 2010. In that testimony, and while under oath, the entire VA panel (Messrs. Murray, Downs and Frye) testified Fee Basis Care was not subject to the FAR. My testimony was guided by the CAO's 2008 declaration and OGC's legal concurrence in his declaration. Unknown then to myself and my staff, OGC had issued a written legal opinion on September 10, 2009, declaring Fee Basis Care to be contractual in nature, subject to the VAAR and FAR. I was totally unaware of this legal opinion until February 2013, when it was provided to me by OGC. Had I been aware of this 2009 legal opinion, my sworn testimony would have been very different in front of the HVAC on July 28, 2010. VA panel members at the hearing collectively provided the HVAC false information, absolutely contrary to the October 2009 OGC opinion. In retrospect, it is indefensible that OGC would knowingly allow VA executives to testify in error to Congress. OGC was involved in preparatory meetings with panel members to ready us for the hearing, and no mention was ever made of their 2009 legal opinion].

The non-disclosure of illegal acts to Congress by VA senior leaders in 2010, as cited immediately above, is reprehensible in my opinion. I unknowingly provided false testimony. Other members of the panel, especially those from VHA, may have been aware of the September 2009 OGC opinion. **[NOTE: The OGC opinion had been provided expressly to the VHA Acting Under Secretary for Health].** If others on the panel knew of the OGC opinion, they may have lied under oath.

It is obvious to me OGC has and continues to obscure facts. As indicated on the page above, in the contentious meeting on July 11, 2014, when I inquired as to the dire urgency being imposed upon me to sign a Departmental waiver, OGC responded that

Department of Justice (DOJ) had recently ruled the VA must consider all Fee-Basis actions as being FAR-based, and thus the necessity for instant actions. There is no doubt in my mind this was an intentional deceptive declaration by OGC. The senior VA OGC official citing DOJ's ruling as the impetus for urgency, knew VHA had been violating the law since at least 2009. After all, OGC had authored and promulgated the legal opinion declaring Fee Basis Care to be FAR-based. Based on my written inquiry in January 2013, OGC had confirmed in writing the fact VHA was violating the law. **[NOTE: Others included in this correspondence were Messrs. Matkovsky, Foley, and Heard].**

In April 2013, I requested assistance from OGC in moving forward to accomplish ratifications against unauthorized commitments in the Fee Basis Care program. A senior OGC official responded, "While the DaVita case is still in play, I recommend not moving forward." And finally, as previously stated above, Secretary Shinseki had been briefed and was provided a white paper in May 2013, wherein it was pointed out to him VHA was violating the law.

In May 2013, I provided written certification to Judge M.E. Coster Williams, in the U.S. Court of Federal Claims that as VA's Senior Procurement Executive, neither I, nor my office, have granted any delegation of contracting authority in any greater dollar limit exceeding $10,000 to the officials set forth in VAAR 801.670-3. My certification was required in response to ongoing litigation in The U.S. Court of Federal Claims, in the case of Davita, Inc. v. The United States. The VA OGC drafted my legal declaration. OGC knew full well at this time that billions of dollars had been unlawfully obligated by VHA in amounts exceeding $10,000 per transaction. My certification is irrefutable proof the OCG knew VHA was violating the law prior to July 11, 2014.

Bafflingly, given all the above correspondence and discussions early in 2013, including revelation of the October 2009 legal opinion, OGC led everyone in attendance at the July 2014 meeting to believe DOJ's "recent decision" was the momentum behind the urgent need to comply with the law. They knowingly led the assembled group to believe this was an emerging event. In fact it was old news, and OGC knew full well we had been violating the law for years. **[NOTE: I believe it may have been an intentional distortion to keep the VA Secretary, at that time Mr. Gibson, from discovering the facts].** I remain confounded by this apparent lack of integrity by a number of VA senior officials in attendance at that meeting.

I have received no support from my boss Mr. Haggstrom in my pursuit to put an end to the lawless behavior with regard to Fee Basis Care. As indicated previously above, I made a plea for his assistance in January 2013. He elected not to engage…. not a single word written or uttered regarding the matter from him. His silence ended only after the contentious meeting on July 11, 2014, when he threatened me for resisting concession to the VA Chief-of-Staff in the contentious meeting. His written recriminations were and remain very disturbing to me. His illegitimate

pressure stopped abruptly when I told him I had turned matters over to the OIG at an earlier date in a Hotline complaint, and my complaint had been accepted.

On March 17, 2015 Mr. Haggstrom's interest spiked momentarily, when he inquired during a meeting in my office area as to the status of this issue. This was his first inquiry since July 2014. His interest seemed to be kindled when I reminded an assembled senior-leader group working on MyVA transformation tasks, that VHA was illegally obligating funds in the amount of $5B annually for Fee Basis Care. His interest waned instantly after I reminded him VHA had summarily rejected the proposed solution in November 2014. Again, in my opinion he does not appear to understand his role as the VA CAO. Mr. Doyle, VHA's HCA, was also in the meeting and did not utter a word, even though the illegal acts are his direct responsibility.

As indicated on page 10 of this correspondence, I had also requested assistance from the VA OIG in this matter in March 2013. This was the related instance wherein a senior OIG official questioned my motive in reporting the unlawful behavior. Although the OIG formally accepted my hotline complaint in April 2013, I was never questioned by the OIG and am unaware of any ongoing investigation by them into these matters.

Care is still being provided for veterans without compliance with Federal laws. Each and every instance where an unauthorized commitment of government funds takes place requires ratification by a duly appointed Federal contracting officer. No ratifications have been executed. The Department continues to pay invoices for these unauthorized commitments, even though VA and Federal financial regulations prohibit payment without ratification. These are improper payments. The volume of improper payments by the VA Office of Finance is mammoth. I am told VHA obligated approximately $5 billion in both 2013 and 2014 against the Fee-Basis Care program alone, and these violations of the law extend back many years.

We must cease this illegal activity immediately. We must then clean up the chaos created by this gross mismanagement of government funds and illegal activities. Had Messrs. Beutel and Doyle not conspired in estopping my attempts to report this illegal activity to Congress nearly two years ago, we could have been well on our way to fixing it.

Illegal use of Government Purchase Cards and Unauthorized Commitments: In October 2012, I learned government purchase cards (GPCs) were being used across the VA in violation of Federal law. The scope of the problem appeared to be enormous, covering nearly every major organization in the VA. I immediately contacted Mr. Haggstrom to outline the problem. He demonstrated little interest and provided no direction.

[NOTE: Government Purchase Cards may only be used as a procurement method up to $3000 for products and services. These individual actions are commonly referred to as a micro-purchase. Rules for the use of GPCs for

micro-purchases are clear-cut. To the credit of all, the GPC program for micro-purchases appears to be well administered across the VA. The GPC may also be used for purposes of payment for procurements above $3000. This is the area where enormous malfeasance has taken place in VA. Above $3000, the card may be used only to pay a properly certified invoice against a properly awarded contract. Above the $3000 threshold, use of the card is not a procurement method; it is only a payment method. When using the GPC for payment, all FAR rules apply. There must be a written contract executed by an authorized CO, there must be competition, there must be determination of fair & reasonable pricing, mandatory contract clauses must be applied, transactions must be recorded in FPDS, there must be separation of duties between contracting officers and payment officials, etc. Our initial discovery in October 2012, revealed the Office of Management had issued approximately 2000 VA personnel GPCs, that were being used illegally. These recipients were using these cards above the micro-purchase threshold in the same manner as micro-purchases. In other words, they were ordering products and services without required contracts, and covering up these illegal unauthorized commitments by liquidating the obligations with the GPC. My office, which provides oversight of the VA procurement system was not aware of these illegal transactions until this time, given no contracts were executed and recorded in FPDS. Again, administration and oversight of the GPC program was declared exclusive domain of the VA Office of Management a number of years ago. Written correspondence reflects senior Office of Management officials didn't understand basic Federal rules surrounding the use of cards for contract payment, while stating it was not their responsibility to ensure compliance above $3000. These situations existed even though they alone issued the cards and are the single VA authority for proper vendor payments].

Given the lack of interest by senior officials to confront the wrongdoing, including the CAO, I submitted a Hotline complaint to the VA OIG on November 26, 2012. My Hotline complaint contained nine allegations as follows:

1. GPCs were being used on a wholesale basis to illegally purchase products and services.
2. Illegal use appeared to have been ongoing for many years, resulting in thousands of unauthorized commitments.
3. Cardholders were not being supervised, to include wholesale violations of the requirement for separation of duties between ordering and paying officials.
4. VA Office of Business Oversight had not conducted appropriate audits for purchases above the micro-purchase threshold (>$3,000).
5. Thousands of unauthorized commitments had not been ratified as required by the FAR.
6. GPCs were being used above the micro-purchase threshold in a wholesale manner without contracts, as required by law.

7. Obligations in No. 6 above were not being entered into FPDS, in violation of Federal statute, also skewing VA small-business accomplishment.
8. GPCs were primarily issued to VHA employees, but also to employees in VA Central Office organizations.
9. Some purchases had been made to pay for Pay Pal and Amazon.COM, expenditures that are strictly prohibited.

The Government Purchase Card program is authorized under the Federal Acquisition Regulation, and is thus the responsibility of the VA Chief Acquisition Officer. Presently, and since the inception of the program in the mid-1990s, day-to-day GPC operations have been delegated to the VA Office of Management. This is a formal delegation, bilaterally executed by the CAO and CFO. Again, I want to emphasize that although authority has been delegated by the CAO to the CFO, responsibility for the program remains with the CAO. Given the above, I was puzzled with the CAO's apparent lack of concern and animation, when I presented allegations of gross mismanagement to him in a program he is overall responsible for. He clearly telegraphed to me it was "not his problem." Although I communicated regularly with him, he hardly ever communicated with me and provided no direction. Frankly, it appeared as if he was avoiding a paper trail.

The OIG accepted my Hotline complaint, and began an investigation in January 2013. My allegations were substantiated in an OIG report dated May 21, 2014. Although the OIG only investigated FY 2012 and 2013 transactions, they estimated 15,600 potential unauthorized commitments, valued at approximately $85.6 million had been made. An OIG footnote in the report stated their estimates were the lower limit of the 90 percent confidence interval.

The problem is indeed much larger in scope than reported by the OIG, and I will provide more details below with regard to prosthetics and purchase card utilization. For instance, the OIG declined to investigate in excess of $50M in unauthorized purchase card transactions I provided to them from the Bronx, NY VA office. They declared my finding to be "outside the scope" of their investigation, because the dollars involved were not from 2012/13.

Time elapsed from my initial complaint until the final investigative report was submitted in May 2014 was 18 months. I am very unhappy it took the OIG what I consider to be an excessive amount of time to investigate a subject that is not complex. During this unnecessarily elongated 1.5-year investigation period, lawlessness continued unabated across the VA.

Although I believe the OIG findings represent a stunning display of gross mismanagement, to date, not a single unauthorized commitment has been ratified. Not a single person at any level has been held accountable for violating the law. Office of Management SES members responsible for the GPC program received promotions and bonuses, subsequent to and in spite of these disclosures. Senior executives in organizations where illegal transactions were made also received

bonuses. It is now confirmed millions of dollars have been obligated without the benefit of contracts in violation of Federal laws, and apparently nobody is accountable.

The CAO and CFO stated in their reply to the OIG investigation they would identify specific unauthorized commitments by April 2015, and submit violations to Heads of Contracting Activities for action. I protested vociferously regarding this lack of urgency to Mr. Haggstrom, Helen Tierney and the OIG. The OIG wrote to me, stating they would look into my complaint. I never heard back from them. Mr. Haggstrom and Ms. Tierney never bothered to reply. My complaints may have caused them to speed the process slightly, as they issued reports in February 2015 to VA HCAs, requesting ratifications be processed on thousands of illegal purchase card transactions encompassing millions of dollars.

Unfortunately, the Office of Management did not complete their task, nor were they pressed by the CFO, CAO or OIG to do so. In order to determine whether purchase cards were improperly used above $3,000, it is necessary to examine two elements. First, whether the official who used the card for payment had the authority, e.g., a contracting officer's warrant. Secondly, an examination must be made to determine if each payment transaction was the result of a properly executed contract. The Office of Management only accomplished the former. Thousands of procurements above $3000, where payment was made with the government purchase card, must be examined to determine if contracts were executed. Procurement above the micro-purchase threshold without a written contract is an unauthorized commitment, even if the perpetrator had a CO warrant. A CO warrant does not license its holder to act outside the law. Illegal acts must be ratified to protect the government. I can state emphatically and without reservation, that over the years billions of dollars have been spent illegally without contracts using this method across VA, but primarily in VHA.

It is now almost 2.5 years since I reported the unlawful activity surrounding GPCs to the VA OIG. Many of those responsible for illegal actions have departed the VA, and the excessive lapsed time will surely render it impossible to ascertain facts in many cases. Mr. Haggstrom told me on February 20, 2015 and again on February 27, 2015 he has no idea what to do about the enormous number of unauthorized commitments.

The law is explicit. These violations of public trust must be ratified, and done so expeditiously. The CAO is responsible for the purchase-card program, and yet there was no correspondence from him to the CFO demanding compliance, nor any consideration of removing delegated authority from the CFO due to gross mismanagement. The VHA HCA, Mr. Doyle, acts as if he is not responsible for the problems in VHA, although he is totally responsible for the VHA Government Purchase Card Program and for ratification of all unauthorized commitments in VHA.

It is simply incomprehensible to me that gross mismanagement of this magnitude is "business as usual" here in the VA. I managed the government purchase card programs in three Federal organizations before my arrival here at VA, and I can assure you malfeasance such as this would never have been tolerated in those agencies. In any other government agency, this would be treated with great concern, and those responsible would be held accountable. The leaders responsible for this fiasco are allowed to treat this calamity as an "institutional problem" instead of a leadership problem. The VA's CFO and CAO are indeed overall responsible. The "institution" called VA is not the culprit. Leaders are at fault and must be held accountable.

In my opinion, no cardholder who violates the law can be held accountable until those who head this critical program are held accountable. I fully understand why this is not a priority in Mr. Haggstrom's office, as he has tolerated unauthorized commitments in his inner circle. Personnel who work directly for him are guilty of violating the law and have not been held accountable. The senior VA enforcer has little ground to enforce the law if he doesn't set a personal example.

I have raised considerable ruckus about this issue, and I have been met with opposition at every turn and from every corner. For instance, on May 29, 2013, while in a conference call with an SES from the Office of Inspector General, I opined that someone must be held accountable for the billions of dollars in services and products purchased in VHA without benefit of contracts. I was referring specifically in that conversation to billions of dollars illegally obligated by warranted contracting officers in VHA for prosthetics, without required contracts, and their illegal liquidation of obligations via Government Purchase Cards to avoid ratification actions. **[NOTE: I will describe below the billions of dollars purchased without contracts for VHA products, and expressly prosthetics].**

I was absolutely floored when the OIG official replied, "Nobody cares. There is nothing that can be done," and further, "The OIG has outlined these issues in previous official OIG reports with no action being taken against anyone." She went on to state, "That it is a waste of time for the OIG to continue to investigate these matters, and that other Government agencies are also violating Federal regulations via obligations without contracts."

There were at least four witnesses to her statement, which I immediately made a matter of written record. When I forwarded it to her and expressed my dismay with her declaration, she denied making it. I don't blame her for her frustration. Nobody is held accountable. However, the laissez-faire, dismissive attitude demonstrated by this particular OIG SES is intolerable in my opinion. If the OIG isn't in the business to ensure the interests of taxpayers are protected, our last line of defense against waste, fraud and abuse is nil.

CITING FALSE INFORMATION TO CONGRESS: In a letter dated March 5, 2012, Rep. Bill Johnson, Chairman, HVAC Subcommittee on Oversight & Investigations,

requested answers to a lengthy series of questions regarding VA contracting practices with regard to prosthetics. The VA Deputy Secretary replied to Rep. Johnson's inquiry in behalf of Secretary Shinseki in correspondence dated March 23, 2012.

The fact sheet provided to Rep. Johnson by the VA Deputy Secretary, Mr. Gould, contained false information. This information was known to be false by the Deputy Secretary when he signed the letter on March 23. Specifically, the Deputy Secretary stated seven times in the letter that with regard to purchases of prosthetics, the VA is "not required by law to follow Federal Acquisition Regulations (FAR), VA Acquisition Regulations (VAAR) and Competition in Contracting Act (CICA) requirements." These statements are patently false. I was in the meeting wherein he signed the document and fervently warned him the information was untruthful and should not be conveyed. He was encouraged to sign the document by former senior VHA official Phil Matkovsky, the former VA Chief Technology Officer, Mr. Peter Levin, and the Office of General Counsel. My supervisor, the CAO was silent, offering no opinion whatsoever.

The VA Deputy Secretary signed the document without staffing it, which is nearly without precedent in the VA. Most notably, the document was processed in a record-breaking 18 days, also an almost unheard of feat in VA Headquarters. He did not seek concurrence from me or any other staff offices with the exception of OGC. He knew I would never concur due to falsification of facts.

[NOTE: The delegation to warrant all VA contracting officers is vested in the VA Senior Procurement Executive. As the current SPE, I grant authority to contracting officers to obligate government funds exclusively under the FAR. In fact, VHA contracting officers assigned to obligate funds for prosthetics were then warranted under my authority. I had not authorized any VHA contracting officer to obligate government funds under any authority except the FAR, and informed the Deputy Secretary of that fact. Unknown to me prior to this time, senior leaders in VHA had allowed VHA contracting officers to violate the terms of their warrants by purchasing prosthetic products above the micro-purchase threshold ($3000) without using contracts, as required by Federal law. These contracting officers were simply ordering items, and making payment using the government purchase cards VHA and VA's Office of Finance had issued them. VHA senior officials knew full well this was illegal, but allowed their contracting officers to engage in the activity as an "easy button" method of procurement. Each of these transactions constitutes an unauthorized commitment of government funds, and each requires a separate ratification action].

The following Friday I met with the VA Chief of Staff, Mr. Gingrich, and Mr. Tom Leney, Office of Small and Disadvantaged Business, during a regularly scheduled meeting on small-business goal performance. In that meeting, I informed Mr. Gingrich I was taking steps to remove all prosthetics obligation data from Federal

Procurement Data System (FPDS). I further stated VA would undoubtedly not achieve our annual small business goals with this removal, as our denominator (total Department FPDS acquisition spend) would subsequently be reduced by perhaps $1B or more. He angrily demanded to know why I was directing such drastic action, while placing the Department in jeopardy of not achieving its small business goals. I informed him only dollars obligated using FAR-based contracts are authorized entry into the Department's FPDS acquisition spend record. I also advised him I was moving to rescind all contracting officer warrants for VHA prosthetics personnel.

The VA Chief of Staff sternly asked why I didn't consider dollars obligated for prosthetics to be FAR-based transactions. I informed him I did, but the VA Deputy Secretary unilaterally made the decision they were not FAR based, and had in fact informed Congress of the same in the March 23 letter. I further told him all prosthetic contracting officer warrants would be rescinded because they had no need for warrants, given they were obligating prosthetic funds outside the FAR. The VA Chief of Staff became visibly angry, and directed me to reverse the Deputy Secretary's decision. Given I accomplished my goal, admittedly a bit backhandedly, I did not proceed with my plan to remove prosthetics obligations from FPDS, nor remove CO warrants.

I am informing you of this so that you understand just how low past leadership has been willing to stoop. In 41 years of Government service, I have never seen anything comparable with Deputy Secretary Gould's arrogant, deceitful actions in this matter. I continue to be deeply haunted by his behavior, and am ashamed I'm a member of the VA senior leadership team who intentionally lied to a Congressional member.

The alleged wrongdoings cited in the letter from Congressman Johnson were in fact true. Had the Deputy Secretary provided a truthful response, the Department would have potentially been subject to Congressional scrutiny again for illegally circumventing Federal procurement laws. Hearings, such as those conducted in January and February 2012 surrounding illegal procurement of VHA pharmaceuticals may have ensued. The Department may again have been exposed for flagrant mismanagement and reckless stewardship. I am unaware that any follow-up was ever made with Congressman Johnson to inform him of the untruths told.

I am bringing this information to your attention to illustrate how Deputy Secretary Gould's intentional deceptive actions and callous disregard of Federal law gave license to others to lie and cheat. He sent a clear message to everyone … the message being it is okay to obscure wrongdoing, and those who do wrong are not accountable. Unfortunately, his irresponsible legacy continues to guide some in the department, as they continue to follow his lead in disregard of our obligation to preserve the public trust.

BILLIONS OBLIGATED FOR PROSTHETICS WITHOUT CONTRACTS: In a letter dated September 26, 2012, Rep. Bill Johnson, Chairman, HVAC Subcommittee on Oversight & Investigations, requested answers to questions regarding VA contracting practices with regards to simplified acquisition procedures.

VHA was assigned to reply to Rep. Johnson's inquiry. In stark contrast to the example I cited above for the previous speedy reply to Mr. Johnson, a reply was not provided until nearly 11 months after receipt of his inquiry, on July 29, 2013. **[NOTE: Mr. Johnson departed the HVAC during this extensive and inexcusable delay in replying to his questions. Thus, the reply was addressed to Rep. Michael Coffman, also a member of the HVAC].**

I personally authored the final version of the enclosure to the letter, although VHA senior officials had been assigned to write it. The final draft, received from VHA prior to my rewrite and which I retain, was nothing short of deception and misinformation. Accordingly, I took it upon myself to completely rewrite the enclosure. Mr. Haggstrom approved it and Secretary Shinseki signed the cover letter.

The primary issue reported in the correspondence to Mr. Coffman, was verification that a VHA employee improperly and deceptively entered spend data into the Federal Procurement Data System. This entailed an amount in excess of $50M spread over hundreds of transactions, in which funds had been illegally obligated without use of contracts. I'm confident Mr. Coffman is business savvy, but I doubt he ever connected the dots, as he was not privy to the original request for clarification sent by Mr. Johnson.

These illegal obligations were made by a number of personnel within the Veterans Integrated Service Network (VISN) 3, without awarding contracts as required by the Federal Acquisition Regulation. The VISN 3 Government Purchase Card coordinator then sloppily hand-jammed the transactions into FPDS, attempting to obtain small-business credit (without regard for whether purchases had been made from large or small business, and without regard for the year of obligation). It was simply happenstance his deceptive behavior was detected. His actions were a classic case of an attempt to deceive the public. As I recall, the transactions were from FY 2010 and FY 2011.

No official investigation was ever conducted. No ratification actions were made as required by Federal statute. In fact, the perpetrator was so bold as to later approach me in writing to ask if VISN 3 could again begin using the Government Purchase Cards as a means of procurement above the micro-purchase threshold. I curtly reminded him VISN 3 never had authority to use the card in the manner he was proposing, as it was illegal.

No person(s) were held accountable for these illegal actions. As stated on page 18 above, the OIG refused to accept my VISN 3 allegations in their investigation of GPC

wrongdoing, declaring them "outside the scope" of their investigation. They refused any allegations or evidence outside the 2012-2013 timeframe, which I consider bureaucratic nonsense. At the least, they should have opened another separate investigation into the matter.

This revelation of wrongdoing in VISN 3 triggered me to begin an informal review of purchases being made by VHA contracting officers, specifically in the prosthetics arena. My staff subsequently provided me information reflecting purchases were being made for prosthetic items without required contracts. Warranted contracting officers were simply ordering products from vendors, and paying for these products with purchase cards, regardless of the fact many of the procurements exceeded $3,000. This appeared to be taking place on a wholesale basis across VHA, and facts subsequently provided substantiated this was the case. When I confronted VHA's Mr. Doyle regarding this matter on several occasions, he refused to reply to my email correspondence.

Further reviews revealed hundreds of unqualified VHA personnel had been delegated contracting officer authority, and these personnel were being allowed to violate the terms and limitations of their warrants. **[NOTE: In the period before 2011, VA HCAs were authorized to warrant personnel up to the Simplified Acquisition Threshold ($150,000). Under this delegation of authority from the SPE, previous VHA HCAs had improperly warranted hundreds of unqualified personnel to serve as contracting officers. Due to this improper execution of delegated authority, in 2011 I rescinded all VA HCAs' authority to warrant COs, consolidating all authority under myself as the Senior Procurement Executive. At the same time, I directed them to provide me a current record of all COs they had previously warranted under their delegation. The VHA HCA failed to provide my office a complete, accurate list. In fact, as it turned out, there were hundreds of contracting officers assigned to procure prosthetics, who did not meet the statutory qualifications for education, training and experience, necessary for certification and appointment. They were fully unqualified to be Federal contracting officers. It required many months of interaction with the VHA staff to accurately baseline the total numbers of warrants that had been issued by VHA prior to 2011, and remove warrants from unqualified personnel].**

In an odd turn of events, the VHA Head of Contracting Activity, Mr. Doyle, maintained he had no authority over VHA contracting officers assigned to procure prosthetics. I considered his notion bizarre. As the HCA, he is delegated responsibility and concomitant authority to operate a full-service contracting organization. This delegation requires he ensure compliance with all laws and regulations related to Federal contracting. He cannot indiscriminately decide he isn't responsible for all facets of the VHA procurement mission.

In this instance, Mr. Haggstrom acted decisively and correctly in his role as the VA CAO. He directed the illegal activity cease in December 2012. Subsequent to his

directive and in late December 2012, Deputy Secretary Gould improperly rescinded Mr. Haggstrom's appropriate and lawful directive.

By rescinding the CAO's directive, the VA Deputy Secretary allowed unqualified VHA contracting officers to continue procurement of prosthetic devices without contracts, in violation of Federal law. Incongruously, in this instance, Mr. Gould no longer maintained VA had the authority to procure prosthetics "without regard to any other law." He had completely changed his mind in this regard. For reasons unknown to me, he now agreed the FAR did apply. As previously stated on page 21 above, on March 23, 2012 the Deputy Secretary had informed Rep. Bill Johnson that VA is "not required by law to follow Federal Acquisition Regulations (FAR), VA Acquisition Regulations (VAAR) and Competition in Contracting Act (CICA) requirements" in the purchase of prosthetics.

On January 14, 2013 I sent an email to Mr. Haggstrom, seeking assurance from him that I would not be held accountable for illegal decisions made by VA senior leaders to continue violating fiscal and contracting statutes, and specifically the decision to allow procurement of VA goods and services without contracts. In a reply that same day, Mr. Haggstrom wrote, "Jan … what you are asking for is way out my control."

In late January 2013, Mr. Gould allowed my office to put in place a stopgap measure that met basic requirements for the FAR. All requirements above $25K were to be procured by qualified VHA contracting officers. He allowed I could not remove warrants from unqualified personnel (although I protested otherwise). He directed these unqualified contracting officers could continue to hold warrants until September 30, 2013, and obligate funds up to $25K. He directed by September 30, 2013, VHA was to have transitioned all contracting activities to qualified, properly warranted 1102 series contracting officers.

The unlawful activity did not end. I currently have on my desk a spreadsheet of obligations made by VHA for FY 2013 and the first six months of FY 2014, using the government purchase card as payment. This spreadsheet reflects there may have been as much as $1.2B in prosthetics purchased sans contracts, in violation of Federal law during this 18-month period. In the past 60 days, I visited a major VHA hospital, wherein they reported they did not discontinue the illegal practice until October 2014.

The government purchase card has been used to camouflage these unauthorized commitments. Contracting officers, armed with government purchase cards, simply procure products without contracts, and liquidate the illegal obligations using the purchase card for payment. VA Office of Finance representatives are not properly engaged in the process. Each of these illegal procurements and subsequent payment constitutes an improper payment. Neither the VA Office of Management, nor its subordinate Office of Business Oversight, police these transactions to ensure contracts have been put in place for each procurement above the micro-purchase threshold. Given no contracts are executed, the procurements are not entered into

Federal Procurement Data System as required by statute. Taxpayers are cheated out of knowing how these funds are being obligated. Suppliers are cheated out of the opportunity to compete for government sales. Prices paid for products may far exceed fair & reasonable prices. Efficacy and safety requirements are nil, given there are no contract terms & conditions. Each of these individual transactions constitutes an unauthorized commitment, requiring investigation and ratification by a warranted contracting officer. To date, no ratifications have taken place.

Mr. Haggstrom and the CFO are fully aware of these issues. I recently recommended to Mr. Haggstrom he strongly consider rescinding the CAO delegation of authority to the CFO to run day-to-day purchase card operations, due to their gross mismanagement of this program. As of this date, he has not acted on my recommendation.

These flagrant violations of law will soon be made public, regardless as to whether you elect to do anything concerning this instant request for assistance by me. The Government Accountability Office conducted an entrance interview for the purpose of commencing an audit of VA's Government Purchase Card Program on March 18, 2015. All issues outlined above are sure to become part of GAO's report to Congress in the very near future.

I have no idea whether either Mr. Haggstrom or Ms. Tierney have related these problems to yourself or Mr. Gibson. In my opinion, this is a colossal governance failure in a program operated by the CFO. Basic Federal rules, including internal VA regulations, prohibit liquidation of obligations without a legal obligation of funds. This is the elephant in the room that others pretend not to see. Most disappointingly to me, SES members in the Office of Management are not willing to confront these issues head on, as they are definitely improper payments. This was the issue I passionately attempted and failed to confront the VA Senior Assessment Team with in late 2014, as indicated on page five of this correspondence.

ILLEGAL USE OF FEDERAL SUPPLY SCHEDULES AND OTHER WASTE & ABUSE:
In May 2014, I learned VHA is grossly violating the Federal Acquisition Regulation (FAR) with regards to products acquired using VHA medical/surgical prime vendor (MSPV) contracts. These illegal actions, which continue today, are the result of a tangled web of poor decisions by senior leaders, and in some cases bad legal advice by the Office of General Counsel. Although I took immediate actions in an effort to right these violations, my supervisor, Mr. Haggstrom, and the VHA Chief Procurement Officer, Mr. Doyle, continue to thwart my efforts.

Medical/Surgical Prime Vendor contracts are designed to be VHA's foremost means to efficiently obtain the broad-range of medical/surgical supplies required across the VHA health-care enterprise. Multiple MSPV contractors receive and process individual requests, while delivering products on a daily basis across the VHA health-care system. This methodology is commonly referred to as a just-in-time (JIT) system. The system is designed to enable medical facilities to order products

one day, and generally receive them the following day. This JIT system eliminates the need for warehouses and expensive inventories of products across the 900+ VHA medical facilities.

MSPV contractors deliver products furnished from underlying Federal contracts awarded by VA contracting personnel. These contracts include Federal Supply Schedules (FSS), VA National Contracts, Blanket Purchase Agreements, Basic Ordering Agreements with Ability One nonprofit agencies, and local or regional VHA-awarded contracts. Essentially, prime vendors are nothing more or less than firms we hire to distribute government-furnished supplies on a JIT basis.

Due to continuing allegations of impropriety, in May 2014 I requested a briefing from the VA National Acquisition Center (NAC) concerning the medical/surgical prime vendor contracts. **[NOTE: The VHA is responsible for defining their requirements under the medical/surgical prime vendor program, and managing the program with regard to cost, schedule and performance. The MSPV program currently resides under the direction of VHA's Chief Procurement and Logistics Officer, Mr. Doyle. The VA National Acquisition Center, which reports directly to me, awards and administers prime vendor contracts on behalf of VHA and several other government agencies].**

What I learned was extremely alarming. Officials at the NAC informed me VHA employees were illegally ordering products directly from a "shopping list" of items that are on FSS contracts. The NAC prime vendor contracting officer stated current ordering procedures are not consistent with program intent at the time of contract award, and are not compliant with MSPV contracts or ordering officer instructions. The "shopping list" referred to above is estimated to contain nearly 400,000 items, and is often being used indiscriminately and not in accordance with the FAR. This is blatantly illegal.

[NOTE: FAR 8.4 requires FSS orders be competed under most circumstances. There are three levels of competition, depending on dollar thresholds of anticipated orders:

1. **At or below the micro-purchase threshold (<$3000). No competition is required.**
2. **Over the micro-purchase threshold but not exceeding the simplified acquisition threshold ($3000 to $150,000). COs must solicit at least three FSS contractors.**
3. **Over the simplified acquisition threshold ($150,000 and upward). A request for quotation must be utilized].**

You may be aware the VA was delegated authority to manage nine categories of FSS by the General Services Administration many years ago. The VA National Acquisition Center in Hines, IL awards and administers these FSS contracts. While VHA is the NAC's largest customer, approximately 40% of the $18B in annual sales of medical products and services are attributed to other government agencies, such as Department of Defense and Health and Human Services.

Since 2002, it has been official VA policy to award single or multiple-award BPAs to the maximum extent practical against FSS contracts awarded by the VA NAC. BPAs provide a simplified way of filling repetitive needs. By establishing BPAs against FSS contracts, VHA saves vast amounts of administrative time, eliminates thousands of duplicative contracting transactions across the VHA, and take advantage of quantity discounts. Other government agencies using our MSPV contracts benefit in this manner as well. Award of BPAs at the national level are absolutely essential in order for VHA to fill repetitive needs for medical/surgical supplies.

Once BPAs are awarded, the day-to-day business of acquiring medical/surgical products at the operational level becomes extremely convenient and expeditious. Designated ordering officers (versus contracting officers) may be delegated authority to place orders against these BPAs. This frees up contracting officers for more important duties at the local level. Ordering officers place orders with MSPV contractors, and these contractors in-turn efficiently distribute ordered products to requesting medical facilities. The integrity of the procurement system is assured, as MSPV contractors are required to use underlying Federal contracts. Most importantly, VHA medical-care providers are able to get the medical/surgical products they need in an expeditious manner.

Unfortunately, the rate of BPA formation has fallen precipitously in recent years. VHA officials seem to have little interest in defining their product requirements, which is required to enable award of BPAs at a national level. Again, these BPAs must be awarded to ensure the VHA's just-in-time Prime Vendor system remains capable of providing needed products in a timely manner. One of the major reasons the VHA supply chain is presently in extremis is due to the fact these BPAs are not being executed. When you and Deputy Secretary Gibson visit hospitals across the VA, and clinicians tell you "procurement is broken," this is the root cause.

VHA's intransigence in this matter is inexplicable, and Mr. Haggstrom's failure to force the issue in his role as the CAO is just as perplexing. In 2010, Secretary Shinseki directed us to vastly increase strategic sourcing and spend management via a renewed effort to award BPAs for medical/surgical and prosthetic products. He directed this action officially in an Executive Decision Memorandum, ordering the VHA and Office of Acquisition, Logistics and Construction to put infrastructure and processes in place to accomplish what was then dubbed as the "Integrated Acquisition Model."

In the course of events, VHA received authorization to stand up a commodity management office, under the leadership of VHA's Office of Procurement and Logistics Operations. Approximately 150 personnel were to be hired and engaged on commodity management teams. The purpose of this office was to begin strategically managing all medical/surgical products in a life-cycle management model never before undertaken for these commodities. **[NOTE: This is the same model used successfully for many years by VHA's Pharmacy Benefits**

Management (PBM) Office to manage VHA pharmaceuticals. In my opinion, the $5B PBM program is arguably one of the best-managed programs in the Federal government and it is extremely wise to emulate its success].

It was envisioned these commodity management teams would intensively manage the entire life cycle of medical/surgical commodities by groups. For example, one of these groups is "surgical products" and includes items as varied as sutures, staples and scalpels. It was intended these commodity managers would be intimately familiar with every facet of individual commodities in their respective groupings. They would research and understand market trends, pricing, emerging technological advancements, annual volume data, manufacturers business models, etc. Most importantly, commodity managers were to be the direct interface with VHA clinicians, gaining intelligence on product quality and efficacy, as well as gathering data on physician-preference items and clinician's satisfaction with the overall supply chain.

The VHA has failed in its mission to effectively stand up this office. Currently, there are less than 25 personnel assigned. They are nearly incapable of defining their requirements. Mr. Doyle and his subordinate SES, Mr. Elizalde, openly admit most of the personnel they've hired are incapable of performing. A prominent VHA Senior Executive recently told Mr. Haggstrom and myself the entire organization is dysfunctional.

As an example of their ineptitude, for over two years the Commodity Management Office has been engaged in development of requirements for new MSPV contracts. Thus far they have categorically failed to perform. The current contracts expire in April 2015. Because there is no chance follow-on contracts will be awarded before the current contracts expire, I was recently forced in my role as the SPE, to authorize extension of current contracts for one year. I did so with extreme reluctance, as I know VHA did not work in good faith to define their requirements, which would have allowed award of new contracts on time. In addition, the quantity of new medical/surgical requirements defined by this office is dismally small. Their bleak performance has caused a waterfall of negative issues, which I will detail further below.

In addition to VHA's standup of a commodity management office, OALC was authorized by Secretary Shinseki and the Supply Fund Board of Directors to stand up a new contracting organization in Fredericksburg, VA, dubbed the Strategic Acquisition Center (SAC). The SAC's sole purpose was to award and administer contracts in support of VHA's medical/surgical mission. The SAC was designed to be stood up iteratively. The plan was to hire 40 contract specialists initially, allow them to undertake the mission until they became saturated with work, and hire another 40. Four iterations were planned for in this manner, with an end-state of approximately 160 contracting professionals.

The stand-up was not accomplished according to plan. Mr. Haggstrom allowed Ms. Cooper and Ms. Bower to hire at will, without regard to workload. VHA did not provide requirements to be put on contract, and thus hiring should have stopped when 40 personnel were on board.

The result is appalling. The current workload for each employee is almost zilch. Two SAC employees recently informed my office they have nothing to do. A GS-15 said he was looking for a new job, as he is tired of having no work. A GS-13 was near tears in my office, as she told me she teleworked three days a week, and watched television "all day long" because she has nothing to do. I did not solicit the information she provided. She was genuinely ashamed of her predicament and concerned about her future. We discussed the scandal recently brought to light by the *Washington Post,* with its expose regarding telework fraud within the U.S. Office of Patent & Trade and how this might compare.

While I do not believe there is fraud involved with regard to the SAC and its telework program, there are millions of dollars consumed in waste. It is totally unacceptable that personnel were needlessly hired, in direct contravention of the approved plan for standup of the SAC. Given the SAC has received virtually no work from VHA in the past five years to generate fees, and given that SAC's senior executives irresponsibly hired contracting professionals at an ever increasing pace in spite of little work, we now have severe budget shortfalls. The SAC, which is supposed to operate as a profit center in the Supply Fund, has squandered over $25M in personnel costs, lease expenses and other outlays over the past four years.

This is in addition to approximately $22M this same office wasted on a duplicative procurement management system dubbed Virtual Office of Acquisition (VOA). **[NOTE: The VOA is the system highlighted in two recent VA OIG reports. The first report highlights the waste caused by intentional duplication of systems by Ms. Cooper, Ms. McCutcheon and Mr. Haggstrom. The second report outlines the illegal steering of contracts to a vendor Ms. Cooper had a personal relationship with. Ms. Cooper is the former Executive Director of the Office of Acquisition Operations who now serves as the Senior Procurement Executive at Department of Treasury. She was a direct report to Mr. Haggstrom, and he allowed her to spend unchecked on VOA in 2013, after the first OIG report declared the system duplicative].** My office was required by Mr. Haggstrom to absorb budget shortfalls due in part to these gross instances of waste, fraud and abuse. These budget shortfalls are causing me to cancel or curtail millions of dollars worth of training for our acquisition and supply-chain professionals. Regrettably, these professionals are the very employees who desperately require schooling in an effort to improve our current supply-chain deficiencies.

There is an additional serious consequence derived from VHA's inability to define their medical/surgical requirements, thus allowing the SAC to award competitive BPAs. We are not leveraging our VHA spend. VHA is the largest integrated health-care system in the country, with potentially enormous spending leverage. Five

years ago, at the direction of Secretary Shinseki, VHA and OALC consulted extensively with the five largest medical Group Purchasing Organizations (GPOs) in the U.S. These engagements included meetings with Secretary Shinseki. These GPOs categorically underscored that VHA could realize as much as 20 percent reduction in medical/surgical acquisition costs if we prudently leverage our spending power. It's a no brainer. We must standardize medical/surgical products when practical. We must also purchase using tiered pricing (volume pricing), while facilitating price decreases for ever-increasing quantities purchased. We have not done what we were directed to do by Secretary Shinseki five years ago, and as a consequence, we've wasted billions of dollars via lost opportunities for savings.

CONCLUSION AND RECOMMENDATIONS:

You have emphasized since your arrival we must all strive to do the hard right vs. the easy wrong. You admirably maintain we must ensure utmost integrity in all we do. Under your direction, a new series of training is underway for the entire VA workforce, emphasizing fundamental accountability that must reside in each of us as government employees. The following principles are included in this training:

1. VA employees have a duty to abide by and enforce the law.
2. VA managers and supervisors are held to a higher standard.
3. VA managers and supervisors must:
    - Abide by and enforce all laws;
    - Never commit Prohibited Personnel Practices;
    - Never retaliate against employees who blow the whistle;
    - Take whistleblower disclosures seriously, and when appropriate, investigate;
    - Promote an atmosphere that allows employees to safely report wrongdoings or violations of law, rule or regulation without fear of retaliation; and,
    - Remember that all your actions or inactions reflect on VA.

While these principles are not new, the training you've directed reemphasizes them in a precise and comprehensible way. Clearly I've provided many examples above exposing unmitigated desecration of these principles, both current and past. I believe under your leadership we've made a credible start, but we have much to do to change the corrosive culture that appears endemic, even at the highest levels of VA. Quoting from Winston Churchill, I do not believe we have reached "the end of the beginning" in our quest. The principal duty we all have as stewards of the public trust continues to be violated in enormous fashion.

During the past 60 days I was privileged to visit three major VA hospitals, at the direction of Deputy Secretary Gibson. I took with me several Senior Executives from my staff, and was joined by several senior members of the VHA staff. Our specific mission was to observe the VHA supply chain, and develop recommendations for improvement to Mr. Gibson.

What I observed in all three hospitals were very dedicated, well-meaning VA employees, doing everything they can to serve America's veterans to the best of their ability. However, issues were reported to us exemplifying improper or marginalized internal controls, as referred throughout this correspondence. All point to dramatically ineffective governance at a basic level, as well as potentially corrupt & unlawful practices.

- A senior nurse informed us a long-term care patient's hospital stay had been extended by 9 months, due to their inability to procure an appropriate wheel chair for him.
- A recently appointed prosthetics chief informed us they had recently reduced an astounding, seven-year backlog of 15,000 prosthetic items to a more manageable but still enormous 6000-item backlog. In addition, prosthetics staff informed us the previous director had been using miscellaneous obligations to pay for veterinarian care for veterans' pet dogs. We confirmed these were not authorized payments for "companion dogs." One example cited $70,000 paid for a single dog, using funds meant for veterans' care out of the hospital's prosthetics budget. These expenditures constitute both unauthorized commitments and improper payments.
- It was reported some long-term care patients are being cared for without contracts or any form of written agreement between the VA and care providers. Veterans being cared for under this arrangement may get substandard, potentially dangerous treatment, as there are no written terms & conditions to enforce a minimum standard of care. This also fosters unacceptable legal liability for VA. This hospital staff informed us they are paying for long-term care using miscellaneous obligations. Paying for services without a written contract is clearly an unauthorized commitment of government funds. These are also examples of unauthorized payments by the VA Office of Finance.
- A prosthetics specialist reported a retired VA female employee, previously employed by that hospital, was provided a prosthetic limb. The specialist claimed the individual was not a veteran and obviously not eligible for care by the VA. This appears to be misappropriation of government funds and perhaps violation of additional criminal statutes.

We did not solicit this information. We did not investigate any of these allegations. That was not our purpose. Our purpose was to observe and gather high-level facts surrounding VHA's supply chain. Persons who apparently thought we should know provided the information freely. I concluded this is the "tip of a very sizable iceberg."

Our hospital visits were admittedly transitory, and our reviews superficial, but our observations paint an ever-clearer picture for me. I am now more convinced than

ever our VA center of gravity is not the "veteran experience" per se. I believe substandard veteran experiences are symptoms of greater ill. I conclude our VA center of gravity is "governance" or more explicitly, lack of appropriate governance. Without proper governance, the quintessential "veteran experience" will never be achievable on a customary basis for the veterans we serve.

In my opinion we must begin immediately to comply with Federal laws and hold those accountable who don't, as indicated throughout this correspondence. We must make every effort to right what has been wronged, while fully disclosing our egregious offenses to the American public, Congress, and most importantly, to the veterans we serve. We are wasting hundreds of millions of dollars through waste, malfeasance, inappropriate governance, and stunningly poor leadership by some at senior leadership levels. I needn't tell you every dollar we waste is a dollar not spent in the support of veterans.

I recommend you immediately invite experts in government contracting and fiscal law to meet with my staff and myself for the purpose of examining my allegations. Three immediately come to my mind. These include Dr. Steven Schooner, Professor of Government Procurement Law and Co-Director of the Government Procurement Law Program, George Washington University. Professor Schooner was previously the Associate Administrator for Procurement Law and Legislation at the Office of Federal Procurement Policy in the Office of Management and Budget. Dr. Allan Burman, who formerly served as the Administrator for Federal Procurement Policy, Office of Management and Budget. He is intimately familiar with our VA procurement system, having performed A-123 reviews of procurement functions across the VA on behalf of my office the past four years. And, Mr. Rob Burton, a nationally-recognized procurement attorney, who formerly served as the Deputy Administrator of the Office of Federal Procurement Policy, as well as Acting Administrator for two years.

Each of these gentlemen brings to the mix many years of experience in the Federal acquisition and fiscal arenas, and each is an expert in their own right with Federal procurement law. In addition, I would advise presence of White House counsel, with expertise in Federal procurement and fiscal law. You would also be well served to request attendance of an expert in Federal Appropriations Law (The Red Book) from the General Accountability Office.

I envision this cursory examination of my allegations would serve to make you comfortable my assertions have merit, justifying a much more comprehensive examination. These Federal experts might then provide you recommendations for a way ahead. I believe a bi-partisan, high-level Commission appointed by you may ultimately be required to examine the issues I've raised, and for purposes of providing proposed solutions for effective strategic changes.

CLOSING REMARKS AND OBSERVATIONS ON MOVING FORWARD:
I am going to be direct in my final remarks, as I it would be a waste of my time and yours if I were circumspect. I hope you will accept my observations and professional opinions in the sincere and respectful vein in which I provide them.

To begin, I for one can't envision how "MyVA" will be effectively executed given the current state of affairs regarding VHA's supply chain and financial functions. Fundamental difficulties in each of these critical foundational processes extend much deeper and are much more pervasive than I have depicted here.

I am obviously not an expert in other foundational fields vital to the success of any going concern, such as human resources, information technology, construction & facilities management, training, etc. However, as a consumer at the executive level, and in perusal of OIG and GAO reports, I know each of these foundational processes have major issues as well. Some, such as human resources, are almost totally dysfunctional, and appear to be the Gordian knot requiring a bold solution to fix.

I view VA's ICARE core values as the five footings, or underpinnings, of the indispensible foundation which each of us relies upon to properly take care of our veterans. These footings must reach all the way to bedrock to ensure structural integrity of VA's foundation. These footings are currently defective. Integrity, the most of important of all, is non-existent in some cases at the highest levels, as I've depicted above. As a young man, I worked with my father in the construction business. I have seen with my own eyes, that without strong footings for the foundation to rest upon, the foundation will self-destruct.

In my humble opinion, the ICARE values developed under Secretary Shinseki's leadership, are superb aspirational ideals, and given proper leadership, will constitute magnificent foundational footings for all of VA. Also in my opinion, the solid foundation yet to be built on these footings consists of new and improved core doctrine, policies, processes, procedures, oversight programs, risk mitigation, effective program management, improved electronic tools and many other basic processes across all VA functional business areas.

I believe your plan for implementation of shared or support services across the enterprise is sound in the long run, but defective in the short run. We must install the ICARE footings first, and build a new foundation consisting of those basic-governance elements I've listed in the paragraph above. In my opinion, unless we fix the core of the problem, and force appropriate governance across the enterprise, we are doomed to failure in the long run.

I admit you may not see the all the fruits of your leadership in the relatively short time you have left as our Secretary by going this route. However, without fixing the basic elements of our business, your bold reorganization may not leave a grand legacy. In fact, others and myself believe you may make matters worse unless we fix those things I've cataloged above and more, before reorganizing. We know you

want our veterans to be provided the best of services on a repeatable basis. Those of us who embrace your leadership want it as well; however, we also want sustained improvement long after you've moved on. Without rebuilding the foundation before we reorganize, we can't possibly erect a structure that institutes a sustainable, exemplary experience for our nation's veterans each-and-every-time we serve them.

Reorganization without establishment of proper governance first, seems akin to moving the furniture in a house with a defective foundation. The ambiance will change, but the foundation remains defective with the potential for catastrophic failure. A superficial change will solve nothing in VA. I believe that's where we're currently headed in our rapid pursuit of change, and as a result, we risk form without function, or perhaps even cataclysmic failure.

I for one, recommend you lead us immediately in development of a foundation of concrete, effective governance. Clearly there too is more work to be done in firmly establishing the ICARE principles. I believe you must be ruthless in the installation of ICARE principles. I know "ruthless" conjures up unpleasant connotations for some, but unless you force it with a strong hand, its implementation will be cursory at best. This is a VA very adept at "waiting out the boss." For instance, those who don't understand that integrity is paramount should be moved out of leadership positions straightaway.

I end with a perhaps rhetorical but basic question. Without demonstration of improved, responsible stewardship, why would the American public support ever-increasing and generous annual Congressional appropriations to care for our nation's veterans?

I respectfully request your consideration and assistance in these matters.

\S\
Jan R. Frye
Deputy Assistant Secretary for
Acquisition & Logistics
Department of Veterans Affairs