



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

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VA HEALTH CARE

Improvements Needed for Management and Oversight of Sole-Source Affiliate Contract Development

Statement of Randall B. Williamson, Director, Health Care

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

I am pleased to be here today to discuss our May 2016 report on the Department of Veterans Affairs' (VA) development and use of sole-source contracts with university-affiliated hospitals, medical schools, and practice groups.¹ Since 1946, VA has partnered with medical schools to provide educational opportunities for resident physicians and other types of students and to increase the availability of specialty physicians to treat veterans in VA medical facilities. This partnership has grown to include 124 of the 167 VA medical centers (VAMC) establishing affiliate relationships with at least one university medical school and its associated university hospital. As a part of these affiliate relationships, VA can obtain additional physician services to supplement available VAMC physician services from a university medical school, hospital, or affiliated physician practice group through expanded contracting authority—referred to as sole-source affiliate contracts (SSAC).² Through SSACs, which are available only to VAMCs and their affiliates, VAMCs can obtain physician services directly from the affiliate without competition if those services are necessary to support learning opportunities for physicians during their residency training in VAMCs.³ SSACs serve an important role in helping to ensure that VAMCs can provide specialty health care services for our nation's veterans and support the residency training of a new cadre of physicians. From fiscal year 2011 through fiscal year 2015, VA had nearly 1,200 SSACs valued at almost \$724 million throughout its health care system.

SSACs can be used to fill short-term or long-term needs at the VAMCs and the level of VA oversight they require varies by their value. Specifically, high-value, long-term SSACs have a total initial value of

¹GAO. *VA Health Care: Improvements Needed for Management and Oversight of Sole-Source Affiliate Contract Development*, [GAO-16-426](#) (Washington, D.C.: May 6, 2016).

²See 38 U.S.C. § 8153(a)(3)(A). For the purposes of this testimony, we use the term physician services to describe services provided by physicians and other highly-qualified professionals that are necessary for the operation of clinical departments that train resident physicians at VAMCs.

³See Department of Veterans Affairs, *Health Care Resources Contracting—Buying*, Title 38 U.S.C. 8153, VA Directive 1663 (Aug. 10, 2006). For the purposes of this testimony, we refer to this directive as VA Directive 1663.

\$500,000 or more and provide affiliate services for more than 1 year.⁴ Among all SSACs, high-value, long-term SSACs require the most review from the Veterans Health Administration (VHA) Central Office.⁵ There are two types of low-value SSACs that are distinguished by the length of time the affiliate is providing services to the VAMC, and neither are required by VA policy to receive oversight from VHA Central Office. Low-value, long-term SSACs have a total initial value of less than \$500,000 and provide affiliate services for more than 1 year. Short-term SSACs have a total initial value of less than \$500,000 and provide affiliate services for less than 1 year.

Oversight of the VHA contracting workforce and the contracts they create is provided by the VHA Office of Procurement and Logistics. VHA created the Medical Sharing Office, a component of the VHA Office of Procurement and Logistics, to provide guidance to contracting officers and oversee the development and award of medical sharing contracts, which include SSACs. Both VHA contracting and clinical staff are to work together to plan, execute, and monitor medical sharing contracts. On the contracting side, contracting officers are responsible for developing, awarding, and administering contracts on behalf of the federal government. Each contracting officer works within 1 of the 21 network contracting offices and is overseen by a medical sharing team supervisor within their network contracting office.⁶ Network contracting offices manage all the contracting activities of a single Veterans Integrated Service Network (VISN) that oversees the day-to-day functions of VAMCs

⁴The total initial value of a SSAC refers to the combined value of the contract's base period and any option periods included in the contract. For example, a high-value, long-term SSAC may have a base period of 1 year valued at \$1 million and four option periods that are 1 year each with a \$1 million value for each option period. This high-value, long-term SSAC would have a total initial value of \$5 million dollars.

⁵In this testimony, we use the term develop to describe a multistep process used to initiate, create, and review SSACs. This multistep process includes actions related to acquisition planning for a SSAC, development and issuance of a solicitation used to inform the affiliate of VA's needs, development and evaluation of the affiliate's proposal, and preparation for and negotiation between the affiliate and VA.

⁶There are 21 network contracting offices within VHA that report to the VHA Procurement and Logistics Office in VHA Central Office and manage all the contracting activities of a single Veterans Integrated Service Network (VISN) and all VAMCs assigned to that VISN. At the start of fiscal year 2016, there were 21 VISNs, but VHA is in the process of consolidating some VISNs so that by the end of fiscal year 2018, there will be 18 VISNs.

that are within that VISN's network. On the clinical side, the VAMC seeking the SSAC is to designate a contracting officer's representative at the VAMC to assist in the development of the SSAC and monitor the affiliate's performance once the contract is awarded. Common tasks delegated to the VAMC-based contracting officer's representative include developing the initial information required to begin acquisition planning, referred to as the procurement package, which includes a definition of the services the VAMC needs the affiliate to provide and approvals from leadership officials.

My testimony today discusses the findings from our May 2016 report examining VA's use of SSACs. Accordingly, this testimony addresses (1) VHA's time frames for developing and awarding high-value, long-term SSACs; (2) VHA's use of short-term SSACs and how it oversees their development and use; (3) how much experience the workforce that develops SSACs has and what specialized training VHA provides; and (4) the challenges selected affiliates experienced with the development and use of SSACs. In addition, I will highlight the eight actions we recommended in our report that VA take to help ensure the timely and effective development of SSACs, the professional growth of the VHA contracting staff responsible for SSAC development and award, and effective communication between VHA and its affiliates. VA concurred with these eight recommended actions.

To conduct our work, among other things, we selected five VAMCs—located in Indianapolis, Indiana; Miami, Florida; Minneapolis, Minnesota; Palo Alto, California; and San Antonio, Texas—to visit along with the five network contracting offices responsible for developing and awarding SSACs for these VAMCs. We selected these VAMCs based on VHA reports on the number and value of SSACs. These five VAMCs are each located within different VISNs. At each of these VAMCs, we selected four to six SSACs and reviewed the terms of these contracts and supporting documents to determine the total elapsed time spent by VHA staff in developing and awarding each contract. We reviewed a total of 25 SSACs from these five VAMCs for services provided from fiscal year 2011 through fiscal year 2015.⁷ In addition, we administered a data

⁷These 25 SSACs included 11 high-value, long-term SSACs from three VAMCs; 2 low-value, long-term SSACs from one VAMC; and 12 short-term SSACs from four VAMCs

collection instrument to supervisors responsible for overseeing the development and award of SSACs in all 21 network contracting offices throughout VHA to capture information about various aspects of network contracting offices' experiences developing SSACs, including oversight by the Medical Sharing Office and contracting officer turnover. We also reviewed VA policy documents and interviewed officials from the VHA Medical Sharing Office and the VHA Procurement and Logistics Office, as well as officials from our selected VAMCs and their associated network contracting offices.⁸ Further, we interviewed representatives of the five university affiliates that provided services to VAMCs under the 25 SSACS we selected for review and discussed their experiences with the development of SSACs. For each of our objectives, we reviewed relevant standards for internal control in the federal government.⁹ Further details on our scope and methodology are included in our May 2016 report. The work this statement is based on was performed in accordance with generally accepted government auditing standards.

⁸VA Directive 1663 outlines VA's policies and procedures for the establishment of medical sharing contracts, including SSACs.

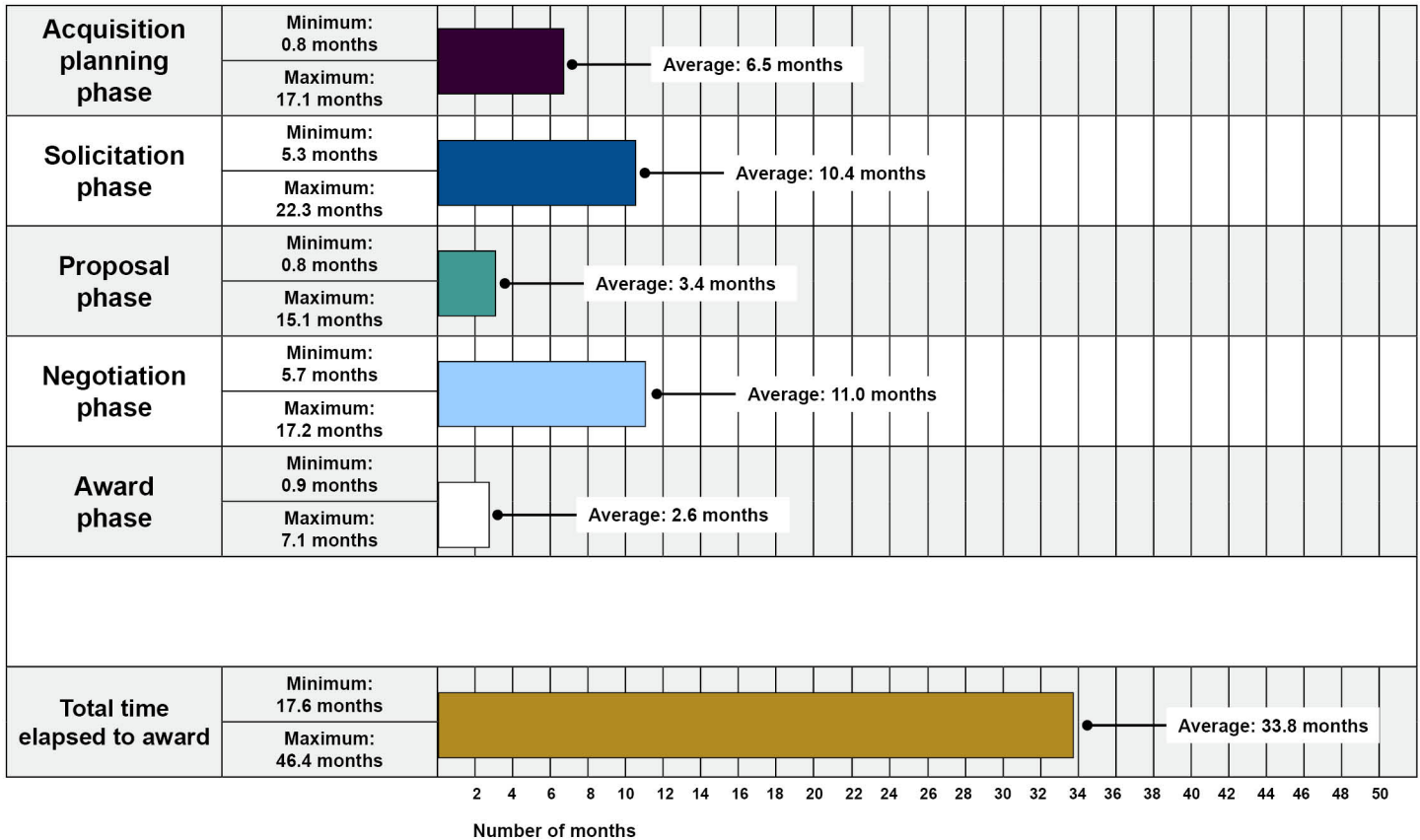
⁹See GAO, *Internal Control: Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

Selected VAMC's Time Frames for Developing High-Value SSACs Can Be Significant, But VHA Has Not Established Standards for Timeliness and Does Not Collect Data

We found that the 11 high-value, long-term SSACs we selected for review from three of the five VAMCs we visited took nearly 3 years (33.8 months) on average to develop and award.¹⁰ (See fig. 1.) The total time required for the development and award of these 11 high-value, long-term SSACs ranged from 18 to 46 months and the longest contracting phases were the solicitation and negotiation phases.

¹⁰One of our selected VAMCs acquired affiliate services exclusively through short-term SSACs and another of our selected VAMCs acquired affiliate services through low-value, long-term SSACs and short-term SSACs.

Figure 1: Calculated Time Frames for the Development and Award of 11 Selected Department of Veterans Affairs (VA) High-Value, Long-Term Sole-Source Affiliate Contracts (SSAC), Awarded in Fiscal Years 2011 through 2015



Source: GAO analysis of VA and Veterans Health Administration information. | GAO-16-721T

Note: Time frames for the development and award of 11 selected high-value, long-term SSACs from three VA medical centers (VAMC) are calculated using dates from available documentation in each contract’s file; however, not all development actions are documented within contract files. As a result, this figure does not include calculations for actions that are not documented. The total time spent developing and awarding a high-value, long-term SSAC is calculated from the date the Veterans Integrated Service Network (VISN) approved the VAMC to acquire the service through a SSAC to the date the contract was awarded to the affiliate. VISNs are required to approve all SSACs before the formal solicitation process can officially begin. The duration of each contracting phase was calculated based on our analysis of selected contract files. Minimum and maximum values in this figure represent the shortest and longest time spent developing and awarding a single contract, as well as the shortest and longest time each phase took for a single contract. Average values in this figure represent the average time spent developing and awarding a high-value, long-term SSAC across all 11 of our selected contracts, as well as the average time each phase took across all 11 selected contracts.

According to leadership officials and contracting officers from all five of the network contracting offices we visited, establishing high-value, long-term SSACs in a timely manner has been challenging for several

reasons, including (1) not always receiving a complete, actionable, and timely initial information package from the VAMC that contains information the contracting officer needs to begin acquisition planning; (2) lengthy review processes for high-value, long-term SSACs; (3) negotiation challenges with the affiliates on the price of high-value, long-term SSACs; and (4) VAMC resistance to developing and pursuing high-value, long-term SSACs. VAMC-based contracting officer's representatives and medical directors from all five of the VAMCs we visited also explained that establishing high-value, long-term SSACs has presented challenges for them. Specifically, 9 of the 14 contracting officer's representatives we spoke with noted that they are often asked to resubmit initial information packages to the contracting officer throughout the development of a SSAC due to form updates or policy changes that occurred since the time they created these documents. Moreover, VAMC officials from all five VAMCs we visited indicated that the length of time it takes to develop and award high-value, long-term SSACs presents many challenges for their VAMCs, including the potential for gaps in patient care and the need to repeatedly establish short-term solutions.

We also found that VHA has not developed standards that can be used to measure the timeliness of developing high-value, long-term SSACs. However, during fiscal year 2016, VHA developed estimates for the maximum duration of each contracting phase, referred to as procurement action lead times (PALT). Currently, the PALT goal for the development and award of a high-value, long-term SSAC is between 20 and 21 months; however, we found that 10 of the 11 high-value, long-term SSACs we reviewed exceeded these PALT goals by as little as 1.4 months and as many as 25.8 months. According to VHA officials we interviewed, PALT goals are not used as performance standards for VAMC, network contracting office, and Medical Sharing Office staff responsible for the development of high-value, long-term SSACs. These officials told us that VHA is currently developing and conducting validity tests of revised PALT goals for several types of contracts, including SSACs, but there is no planned end date for these tests and they do not expect to implement revised PALT goals across VHA until at least fiscal year 2017. These officials explained that the revised PALT goals will be used for setting expectations with VAMC officials for the length of time it should take to develop and award several types of contracts, including SSACs. Federal internal control standards recommend establishing and

reviewing performance standards at all levels of an agency.¹¹ Absent such standards, VHA cannot ensure that its high-value, long-term SSACs are being developed in a timely manner.

Additionally, we found that VHA does not collect data on the length of time each contracting phase took to complete for any SSACs, including the 11 high-value, long-term and 12 short-term SSACs we selected for review. Federal internal control standards state that information should be recorded and communicated to management and others within the agency that need it in a format and time frame that enables them to carry out their responsibilities.¹² However, in contrast with these standards, VA is unable to analyze the time spent in each phase of SSAC development, and this inability has disadvantages in terms of management decisions and accountability for SSAC development. The absence of real-time data on the amount of time being spent within each contracting phase limits VA's ability to make informed management decisions, including changes to the assignment of staff that are either overburdened by their workloads or in need of additional training to build their competency with a particular type of contract or contracting phase. This lack of information prevents VHA from effectively setting clear and consistent objectives for organizational performance and making improvements as needed.

Our report concluded that a lack of attention to the time spent to develop and award high-value, long-term SSACs has resulted in VHA's inability to ensure that contracts are being developed in a timely manner. To ensure the timely development of high-value, long-term SSACs, we recommended that VA (1) establish performance standards for appropriate development time frames for high-value, long-term SSACs and use these performance standards to routinely monitor VAMC, network contracting office, and Medical Sharing Office efforts to develop these contracts; and (2) collect performance data on the time spent in each phase of the development of high-value, long-term SSACs and periodically analyze these data to assess performance. VA concurred with these recommendations and said that it will take steps to address these weaknesses, including the creation of a workgroup that will establish performance standards for development time frames for high-

¹¹See [GAO/AIMD-00-21.3.1](#).

¹²See [GAO/AIMD-00-21.3.1](#).

value, long-term SSACs and the designation of an office within VHA to routinely monitor these performance standards. VA also said that it will assess its current data systems to determine whether a new or different system would be needed to capture all relevant data and that the Medical Sharing Office will collaborate with other stakeholders to determine the need for and the mechanism to collect additional data.

Short-Term SSACs Have Been Used to Overcome Lengthy High-Value, Long-Term SSAC Development Time Frames, but VHA Lacks Effective Oversight for Their Development and Use

We found that short-term SSACs are used to provide coverage to bridge the gap between an expired or expiring high-value, long-term SSAC and its replacement. Specifically, 6 of our 12 selected short-term SSACs were awarded as bridge contracts, which creates duplicative work for VAMC and contracting staff because they must simultaneously develop both the short-term SSAC bridge contract and the replacement high-value, long-term or low-value, long-term SSAC.¹³ Of the remaining 6 short-term SSACs we reviewed, 5 were awarded to allow affiliate services to begin while new high-value, long-term SSACs were being developed for the same services and 1 was awarded to fill a short-term staffing need at a VAMC. In addition, we found that the use of these 12 short-term SSACs was consistent with reasons reported by from the majority of the medical sharing team supervisors from the 21 network contracting offices. Specifically, 12 medical sharing team supervisors from the 21 network contracting offices (57 percent) reported that the most prevalent reason that they opt to award short-term SSACs is to avoid any gaps in services due to the length of time it takes to develop and award high-value, long-term SSACs.

Federal internal control standards state an agency should provide for an assessment of the agency's risk associated with achieving its objectives, including identifying risks through forecasting and strategic planning.¹⁴ However, in contrast with these standards, VHA does not have a policy that requires VAMCs and network contracting offices to engage in timely acquisition planning to ensure that expiring high-value, long-term SSACs are replaced without the need to use a short-term SSAC as a bridge contract. Moreover, VA's governing directive for the development of

¹³See GAO, *Sole-Source Contracting: Defining and Tracking Bridge Contracts Would Help Agencies Manage Their Use*, [GAO-16-15](#) (Washington, D.C.: Oct. 14, 2015).

¹⁴See [GAO/AIMD-00-21.3.1](#).

SSACs does not specify when VAMC and network contracting office staff should begin acquisition planning activities to replace an existing high-value, long-term SSAC.¹⁵ As a result, VHA lacks assurance that its staff are performing and accountable for their roles in ensuring that replacement high-value, long-term SSACs are developed in time and that the agency is minimizing duplicative work when short-term SSACs are used as bridge contracts.

We also found that VHA was further exposed to potential risks associated with using short-term SSACs because the Medical Sharing Office, the VHA Central Office entity with oversight authority of SSACs, does not consistently review available data on all SSACs awarded throughout VHA; in particular, it does not review the level of reliance on short-term SSACs. While this office creates monthly reports for all VISNs and network contracting offices that provide information on the status of their medical sharing contracts, including all SSACs, they rely on network contracting offices to determine if they are selecting the appropriate term for their contracts. This can potentially be problematic because 7 of the medical sharing supervisors from the 21 network contracting offices we contacted and leadership teams and contracting officers from 3 of the 5 network contracting offices we visited told us that at times they have purposefully developed short-term SSACs in lieu of high-value, long-term SSACs because the Medical Sharing Office does not review any short-term SSACs. In fact, we found 6 of the 12 short-term SSACs we selected for review were extended beyond their initial performance periods for up to 11 months resulting in total values for these 6 contracts that ranged from almost \$686,000 to \$1.4 million—well beyond the \$500,000 Medical Sharing Office review threshold. Standards for internal control in the federal government state that control activities should occur at all levels of an agency to help ensure that management's directive are carried out by staff and that top-level reviews of actual performance by agency management are needed to track major agency achievements and compare these to plans, goals, and objectives that were previously established.¹⁶

¹⁵VA Directive 1663.

¹⁶See [GAO/AIMD-00-21.3.1](#)

In addition, we found that 7 of the 12 short-term SSACs we selected for review from two network contracting offices did not follow VA and VHA policy for the development of SSACs. Specifically, we found 5 short-term SSACs we reviewed from one network contracting office where (1) a solicitation was not issued to the affiliate, (2) the affiliate did not provide VHA a formal proposal outlining its services and instead submitted a price quote, and (3) negotiations were not conducted to address potential pricing issues before awarding the final contract.¹⁷ The contracting officer responsible for these 5 short-term SSACs explained that he was often given as little as 10 business days to develop and award a short-term SSAC before the prior short-term SSAC expired and that he did not have the skills needed to conduct negotiations with the affiliate. We found that this contracting officer's supervisor had reviewed all 5 of these contracts prior to their award; however, the review process did not identify the areas that did not adhere to VA and VHA policy requirements for the development of SSACs. Federal internal control standards recommend that agencies establish processes to ensure the proper execution of transactions, including the provision of the proper amount of supervision.¹⁸ However, without ensuring that contracting officers are adhering to VA and VHA policies and network contracting offices are effectively reviewing the development of short-term SSACs as required by VA and VHA policies, VHA may be at risk for overpaying for affiliate services provided through these contracts.

Our report concluded that the lack of attention to this overreliance on short-term SSACs as bridge contracts exposes VHA to risks. To ensure the effective development and use of short-term SSACs, we recommended VA (1) develop requirements for VAMCs and network contracting offices to effectively engage in early acquisition planning for the replacement of expiring high-value, long-term SSACs, (2) prioritize the review of SSAC contract data to identify patterns of overreliance on short-term SSACs that avoid appropriate Medical Sharing Office oversight, and (3) develop standards for the minimum amount of time necessary to develop and award short-term SSACs to minimize cases of nonadherence to VA policy for these contracts. VA concurred with these

¹⁷The other two short-term SSACs that did not follow VA and VHA policy for the development of SSACs had similar policy adherence problems.

¹⁸See [GAO/AIMD-00-21.3.1](#).

recommendations, and laid out plans to develop new requirements and standards while also charging the Medical Sharing Office with conducting data reviews of short-term SSACs.

High Turnover and Limited Training Opportunities Result in Inexperienced VHA Medical Sharing Contracting Officers and Impede the Development of SSACs

We found a high level of turnover among medical sharing contracting officers in all 21 network contracting offices that was exacerbated by a high level of inexperience among contracting officers responsible for developing SSACs. Network contracting office medical sharing teams experienced significant turnover in recent years, with 23 percent (49 of 217) of medical sharing contracting officer full-time employee equivalents (FTEE) in fiscal year 2014 and 27 percent (65 of 239) of FTEEs in fiscal year 2015 either resigning or transferring to another VHA contracting team.

Medical sharing supervisors offered several potential explanations for turnover on medical sharing teams, including job burnout, the complexity of medical sharing contracts, the workload associated with medical sharing teams, and frustration with the layers of review required for these contracts. Medical Sharing Office officials told us that this turnover hinders the SSAC development process because newer contracting officers have greater difficulty developing high-value, long-term SSACs due to a lack of experience and knowledge. They also told us that they believe it takes approximately 5 years for a contracting officer to become experienced in developing medical sharing contracts, including SSACs. We found, however, that more than half of medical sharing contracting officers had 2 years or less medical sharing contract experience and less than one-quarter had more than 4 years of experience developing medical sharing contracts. Federal internal control standards state that effective management of an organization's workforce, such as having the right personnel on board, is essential to achieving results.¹⁹ However, in contrast to these standards, VHA does not have a plan to address medical sharing contracting officer turnover. As a result, VHA lacks assurance that network contracting offices can maintain and develop the contracting officers' skillsets that are necessary for developing complex medical sharing contracts, such as SSACs.

¹⁹See [GAO/AIMD-00-21.3.1](#).

Moreover, we found that limited training opportunities for medical sharing contracting officers further erodes VA's knowledge base for developing high-quality and cost-effective SSACs. The Medical Sharing Office has developed and offered three in-person training courses designed to progressively build a contracting officer's competence in developing medical sharing contracts, including SSACs. Medical Sharing Office officials reported in February 2016 that over 90 percent of all participants for each of the training classes reported that the trainings increased their medical sharing competency and that the information presented would contribute to their job performance. Since fiscal year 2015, however, VHA has not consistently provided training for medical sharing teams in network contracting offices throughout VHA. VHA has canceled some of their course offerings due to budget constraints. In addition, VHA Central Office requested that the Medical Sharing Office cut the class size of each course offering by 25 percent. Federal internal control standards state that agencies should establish good human capital policies and practices, such as appropriate practices for training.²⁰ In contrast to these standards, VHA has not determined how to either provide the existing training courses or develop alternatives that do not require travel in response to a changing budgetary environment. As a result, VHA cannot build the skills of its medical sharing contracting officers and overcome the challenges associated with their inexperience.

Our report concluded that instability in the medical sharing workforce, due to high levels of turnover among medical sharing contracting officers, has limited VHA's ability to develop high-quality SSACs throughout VHA. To develop and maintain medical sharing expertise within the network contracting offices, we recommended that VA (1) create a plan to increase retention of contracting officers that work in medical sharing teams, and (2) develop mechanisms to either provide existing training courses or create training courses that do not require travel for contracting officers working within network contracting offices. VA concurred with both of these recommendations and summarized planned steps to address these recommendations, including the development of a retention plan and soliciting agency leadership for assistance in resource prioritization to fund VHA health care contracting training courses.

²⁰See [GAO/AIMD-00-21.3.1](#).

Selected Affiliates Reported Communication and Coordination Challenges with VHA Regarding SSACs

We found that representatives from the five affiliates that provide services through SSACs to our selected VAMCs noted challenges related to receiving information on changes to VA and VHA requirements for SSACs. These included communication from VHA about what services the VAMC needed from the affiliate, the documentation requirements affiliates needed to submit to support their physician salary pricing, and changes to VHA's approach to negotiations. The affiliate representatives also noted coordination challenges related to responding to SSAC solicitations. For example, representatives reported that it was challenging for them to provide services to VAMCs under short-term SSACs because the length of these contracts does not provide a commitment from VHA for the physicians hired by the affiliate to fulfill the contract. These affiliate representatives explained that it can take a year or longer to recruit a well-qualified academic physician and short-term SSACs do not provide the funding commitment needed by the affiliate to recruit these physicians. Federal internal control standards state that information should be communicated both internally and externally to enable the agency to carry out its responsibilities; for external communications, these standards state that management should ensure that there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency achieving its goals.²¹ In contrast to these standards, VHA's efforts to cultivate better communication and coordination with affiliates at the national level have been limited, consisting of three regional forums with all its affiliates in fiscal year 2012. Since 2012, VA has relied primarily on local coordination with affiliates in lieu of regional forums, due to travel restrictions associated with VA's recent budget shortfalls. As a result, VHA cannot ensure that it is effectively responding to the concerns of its affiliates.

Our report concluded that concerns about VA's communication and coordination with its affiliates, as voiced by representatives from the five affiliates we spoke with, demonstrate potentially ineffective communication streams with these critical partners. To ensure VHA effectively communicates with its affiliates regarding SSACs, we recommended that VA reach out to all its affiliates, identify any concerns,

²¹See [GAO/AIMD-00-21.3.1](#).

and determine the most effective method of communicating with affiliates regarding SSAC development. VA concurred with this recommendation and said that the VHA's Office of Academic Affiliations and Medical Sharing Office will re-engage with the American Association of Medical Colleges to determine the best ways to gather input from affiliates on their concerns and determine the most effective method of communication with them regarding SSAC development. Furthermore, VA added that these offices will evaluate VA's current partnerships with affiliates to identify both highly functional relationships that could be highlighted as best practices and partnerships that could benefit from targeted intervention.

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

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Marcia A. Mann, Assistant Director; Cathleen Hamann; Katherine Nicole Laubacher; Dharani Ranganathan; and Said Sariolghalam.

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