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Audit of Community-Based Outpatient Clinic Contracts

Audit

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to determine whether Veterans Health Administration (VHA) national program offices provided effective oversight of contracted community-based outpatient clinics (CBOCs). VHA uses CBOCs to increase veteran access to health care; these clinics are either VA-owned and VA-operated, VA-leased and VA-operated, or VA-contracted. This audit focused on VA-contracted CBOCs. As of December 2023, VHA had 92 contracts (valued at about \$2 billion) for services at 107 VA-contracted CBOCs. VA medical centers and contracting officers are required to use a standard template to establish consistent CBOC contract requirements. The template includes detailed performance metrics and a contract payment structure calculated using a fixed price per assigned patient per month. To evaluate the effectiveness of program office oversight, the audit team selected a statistical sample of 11 contracts for 19 CBOC locations with performance data from January 2023 through July 2024.¹

The OIG presented its findings to VHA in November 2024, July 2025, and September 2025 and made 12 recommendations to improve oversight. These include better monitoring of contract compliance, establishing more efficient and consistent procedures to develop and maintain billable rosters, and determining whether positive and negative performance incentives should be used to motivate contractors.

On November 3, 2025, the former acting under secretary for health concurred with four recommendations, concurred in principle with the other eight, and provided action plans to implement all 12 recommendations. On February 10, 2026, the current under secretary for health advised the OIG that he is forming a work group to assess and standardize the process for CBOC contract oversight based on this OIG report. He said the results of the work group may change the action plans previously provided by the former acting under secretary.

The OIG is aware that both the Office of Acquisition, Logistics, and Construction and VHA are undergoing significant changes to their structure and operations. The full effect of those changes on the management and operation of CBOCs is unknown as of the date of this publication—but according to the Secretary of Veterans Affairs, the Office of Acquisition, Logistics, and Construction will assume responsibility for all acquisition functions at the department, which will include the CBOC contracts. The OIG will continue to monitor and assess the impact of those changes.

¹ See appendix A for full details on this audit's scope and methodology.

Background

VHA is the largest integrated healthcare system in the United States, providing care to more than nine million enrolled veterans at 172 VA medical centers and 1,197 outpatient sites.² VHA establishes VA-contracted CBOCs when medical facilities identify patients in a region who need access to care but (1) the local VA medical facility does not have the space or staffing to establish a VA-operated clinic and (2) care in the community cannot meet patients' needs.

The Medical Sharing/Affiliate Office (MSO) in VHA's Office of Acquisitions is the national program office responsible for oversight and guidance when VHA acquires healthcare resources, like CBOC contracts, using its statutory authority.³ MSO implements policies and strategies, provides tools to medical centers and contracting offices, and provides administrative oversight in preparing CBOC contracts. The VHA Office of Primary Care is the national program office that provides the clinical requirements for CBOCs; it works with MSO and the VA Office of General Counsel to review and approve CBOC contracts before they are awarded.⁴ CBOC contracts are then awarded and overseen by contracting officers, who appoint contracting officer's representatives from the associated VA medical center to monitor contract performance throughout the life of the contract.

What the Audit Found

VHA's national program offices did not effectively manage the full life cycle of contracted CBOCs. Specifically, program offices' oversight ended after a contract was awarded, leaving VHA without a headquarters-level office to oversee the effectiveness of the contracts for the rest of their life cycle. Furthermore, VHA's policies governing contracts for healthcare resources, including CBOC contracts, did not incorporate all responsibilities required of a VHA program office.⁵ This limited the offices' ability to identify and implement solutions for national issues, which may have adversely affected the care provided to veterans and created administrative challenges for VA medical centers and contracting offices. These issues may also have contributed to contracted CBOCs providing healthcare services that scored below VHA's overall performance metrics, wasted VA resources, and created barriers to competition.

The audit team also found that contract templates did not enable contracting officers to motivate contractors to meet or exceed the required performance metrics or to hold contractors accountable when metrics were not met. This occurred in part because VHA procurement

² VA, "VA Benefits & Health Care Utilization," March 31, 2025.

³ VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office*, February 21, 2023; VHA Procurement Manual, part 873.

⁴ In September 2024, MSO published a news bulletin that removed the requirement for the Office of Primary Care to review CBOC contracts before they are awarded. The bulletin said the Office of Primary Care would continue to collaborate with MSO to maintain the contract template.

⁵ VHA Directive 1660.07; VHA Procurement Manual, part 873.

officials stopped including performance incentives in contracts, based on an interpretation of guidance from VA’s Office of General Counsel.⁶ However, federal acquisition policies require agencies to consider including performance incentives in service contracts “to the maximum extent practicable” to motivate contractors to meet or exceed desired performance.⁷ In October 2024, officials in the Office of General Counsel clarified that the intent of their guidance was to ensure contracting officers coordinated with their assigned legal counsel when considering the use of performance incentives. Without effective means to hold contractors accountable, contracting officers and VA medical centers accepted performance that did not meet contract requirements. Specifically, the contractors for the 11 contracts that the OIG team reviewed did not meet 56 percent of the contract performance metrics, on average, from January 2022 through March 2024. Although the contractors underperformed, they still received full payment for the patients assigned to their clinics.

Next Steps

The comments and action plans from the current under secretary for health and the former acting under secretary for health are generally responsive and meet the intent of the recommendations. The former acting under secretary’s full response is in appendix B.

The comments were only partially responsive for recommendation 2 because the former acting under secretary noted that procedures to monitor overall compliance with contract requirements already exist and that CBOC standards apply to both VA-operated and contractor-operated CBOCs. However, VHA created policies, procedures, and templates specifically for contracted CBOCs. Without a headquarters-level office to monitor the effectiveness of the contracted CBOCs and the templates, VHA limits its ability to identify and take corrective action when contractors consistently do not meet performance metrics. Therefore, to meet the intent of recommendation 2, the work group VHA proposed should identify a headquarters-level office or a collaboration of offices to monitor the effectiveness of both the contracted CBOCs and contractor performance and make appropriate adjustments to the contract templates, if necessary.

The former acting under secretary’s comments were also only partially responsive for recommendation 12, because the former acting under secretary said the proposed work group would review existing procedures to update the CBOC contract template. While a work group could identify areas for improvement, VHA should develop and implement permanent procedures—which could include assigning responsibilities to regularly identify, evaluate, and incorporate commercial practices into the CBOC contract template before publishing updates.

⁶ VA Office of General Counsel guidance, Service Area Office Central, Volume 6, Issue 2, “Legal Corner Making Sense of Liquidated Damages and Disincentives,” February 2017.

⁷ FAR 16.402-2; Office of Federal Procurement Policy, *Appropriate Use of Incentive Contracts*, December 4, 2007.

The OIG will monitor the implementation of VHA's planned actions and will close the recommendations once VHA provides evidence demonstrating sufficient progress in addressing the issues identified.



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Abbreviations

CBOC	community-based outpatient clinic
CMS	Centers for Medicare & Medicaid Services
COR	contracting officer's representative
CPARS	Contractor Performance Assessment Reporting System
FAR	Federal Acquisition Regulation
MSO	Medical Sharing/Affiliate Office
OIG	Office of Inspector General
RFO	Revolutionary FAR Overhaul
VHA	Veterans Health Administration



Introduction

The Veterans Health Administration (VHA) is the largest integrated healthcare system in the United States, providing care to more than nine million veterans at 172 VA medical centers and 1,197 outpatient sites.⁸ VHA establishes community-based outpatient clinics (CBOCs) when medical facilities identify patients in a region who need access to care. Located at sites away from the VA medical centers that manage them, CBOCs can provide primary, specialty, subspecialty, or mental health care or any combination of healthcare services that veterans can receive in an outpatient setting. CBOCs must be operated in a manner that provides consistent, high-quality health care equivalent to care patients receive at any VA medical facility. As of September 30, 2023, VHA had 733 CBOCs.

CBOCs can be VA-owned and -operated, VA-leased and -operated, or VA-contracted sites of care. The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA's national program offices provided effective oversight of contracted CBOCs.

At VA-contracted sites, a vendor is responsible for both the property where the clinic is operated and for the clinic's operation. As of December 2023, VHA had 92 contracts (valued at about \$2 billion) for services at 107 VA-contracted CBOCs—which were initially intended to serve an estimated 283,700 patients during the first year of the contracts.

Oversight Structure

Several VHA offices are responsible for overseeing CBOC contracts. The Office of the Under Secretary for Health provides leadership and direction for VHA, develops and implements healthcare initiatives, and ensures compliance with VHA directives. The VHA Office of Acquisitions supports VHA in purchasing high-quality, cost-effective healthcare products and services. The Office of Acquisitions oversees the Medical Sharing/Affiliate Office (MSO) and network contracting offices.

MSO is responsible for department-level processes to support veteran-centric care through safe, cost-effective healthcare agreements and contracts.⁹ It is the national program office charged with implementing policies and strategies and providing tools to VA medical centers and contracting offices that acquire healthcare resources, including CBOC contracts. CBOC contracts enable VHA to acquire healthcare resources in accordance with VHA's statutory authority and responsibilities.¹⁰ MSO provides administrative oversight and guidance for CBOC contracts and conducts procurement reviews and approvals of contracts before they are awarded. The VHA

⁸ VA, "VA Benefits & Health Care Utilization," March 31, 2025.

⁹ MSO supports agreements to buy or sell health care with affiliated institutions, such as colleges or universities, and facilitates contracts that purchase healthcare resources, such as the services of doctors or clinics.

¹⁰ 38 U.S.C. § 8153.

Office of Primary Care is the national program office that identifies clinical requirements for CBOCs; it works with MSO and VA's Office of General Counsel to review the CBOC contracts before they are awarded.¹¹

Contracting officers award and oversee CBOC contracts at network contracting offices. VA medical centers are responsible for managing all facilities in their healthcare systems, including CBOCs. Because they are also required to ensure consistent, high-quality care is provided at all VA locations, the medical centers are responsible for monitoring CBOC contractors' performance. Medical center staff must verify that contractors perform services throughout the life of a contract; this includes providing contracting officer's representatives (CORs) to monitor and report contract performance to the contracting officers.

In November 2025, the Secretary of Veterans Affairs announced that all VA procurement staff will be operationally and administratively realigned under the Office of Acquisition, Logistics, and Construction. The memorandum indicated that the initial realignment would occur in March 2026 with full implementation no later than September 30, 2026. Additionally, in December 2025, VA announced its intent to reorganize the management structure of VHA, with the goal of improving health care for veterans and ensuring consistent application of VA policies.¹² The OIG will continue to monitor and assess the impact of those changes.

CBOC Contracts

Of the 92 contracts VHA had as of December 2023, VHA awarded 78 contracts—with a total value of about \$1.9 billion—to five contractors. Two of these five received 58 contract awards, representing almost 63 percent of the total number of contracts and almost 75 percent of the total CBOC contract value at the time. Figure 1 shows the breakdown of contracts by contractor as of December 2023 and the total estimated value of those contracts.

¹¹ In September 2024, MSO published a news bulletin that removed the requirement for the Office of Primary Care to review CBOC contracts before they are awarded. The bulletin said the Office of Primary Care would continue to work with MSO to maintain the contract template.

¹² VA, "[VA launches Veterans Health Administration reorganization](#)," news release, December 15, 2025.

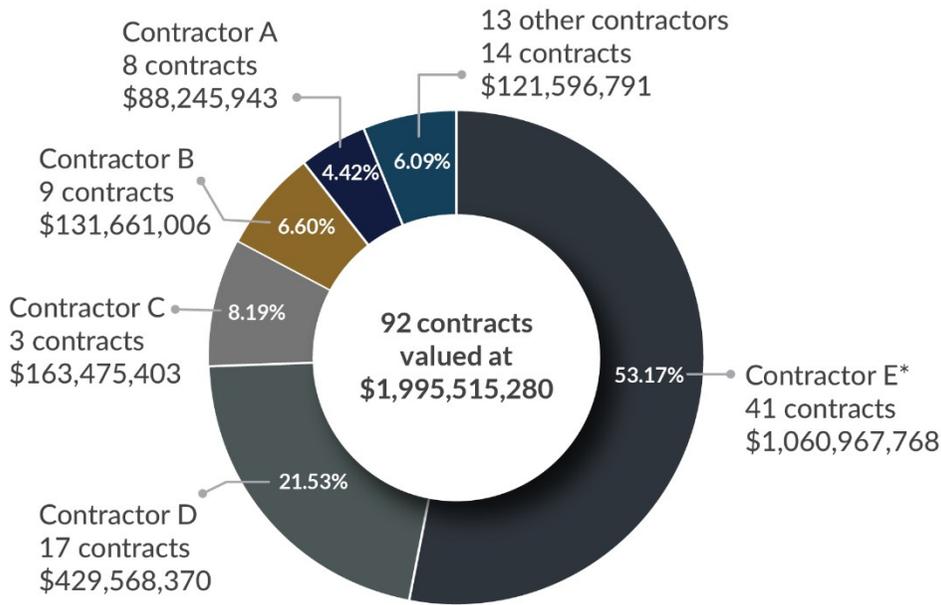


Figure 1. Total value of active CBOC contracts by contractor, as of December 1, 2023.

*These 41 contracts comprise 35 contracts awarded to Contractor E and six awarded to another company that Contractor E acquired in August 2021.

Note: Dollars do not sum due to rounding.

Medical centers and contracting officers are required to use a standard template published by MSO to establish CBOC contract requirements.¹³ Although some aspects of the template can be tailored for each facility, it includes VHA’s standard requirements for key personnel, facilities, and quality of care as well as 22 detailed performance metrics to ensure contractor compliance, such as timeliness of appointments for both new and established patients, staffing, and appointment cancellations.¹⁴ The template also has a contract payment structure that uses a fixed price per assigned patient per month, which is paid monthly to the CBOC contractor. To remain assigned to a contracted CBOC, patients must have had at least one qualifying appointment within a 12-month period.

Requirements for Program Offices

VHA Directive 1217 defines a national program as a system of policies, strategies, and tools designed to produce specific, measurable, enterprise-wide outcomes.¹⁵ Program offices manage national programs and are responsible for developing policies and strategies and providing tools

¹³ VHA Procurement Manual, part 873, “Health-Care Resource Specialized Procurements and Sharing Agreements under Title 38 U.S.C. § 8153 SOP [Standard Operating Procedure].”

¹⁴ The contract requirements template was updated in April 2024 to include 34 performance metrics, among other changes.

¹⁵ VHA Directive 1217, *VHA Central Office Operating Units*, September 10, 2021.

to local facilities to support national goals. They are also responsible for governance, expertise, leadership, and oversight of their programs.

Requirements for Healthcare Contracts

Federal law allows VA to award contracts for healthcare resources and requires VA to buy these resources as commercial services using firm-fixed-price contracts.¹⁶ Similarly, the Federal Acquisition Regulation (FAR) requires agencies to award contracts for commercial services as performance-based acquisitions “to the maximum extent practicable” using firm-fixed-price contracts as the preferred contract type.¹⁷ Performance-based acquisitions are structured based on the results vendors achieve rather than how they perform the work and must include a performance work statement and measurable performance standards.¹⁸ Performance incentives should also be considered “to the maximum extent practicable” for service contracts “when quality performance is critical and incentives are likely to motivate the contractor.”¹⁹ A performance incentive is a motivational tool that relates profit or fee to the results the contractor achieves.

On April 15, 2025, the President signed an executive order that mandated a comprehensive review and simplification of the FAR.²⁰ The project is referred to as the Revolutionary FAR Overhaul (RFO) initiative. VA issued class deviations for VA contracting offices to start using the revised FAR language. The OIG team updated this report based on the RFO revisions and cited changes to FAR requirements as necessary.

¹⁶ 38 U.S.C. § 8153.

¹⁷ FAR 12.207 and 37.1. Updated in Revolutionary FAR Overhaul (RFO) initiative FAR 12.104 and 37.101-1.

¹⁸ FAR 37.6. Updated in RFO FAR 37.101-1.

¹⁹ FAR 16.402-2. Updated in RFO FAR 16.403.

²⁰ Executive Order 14275, *Restoring Common Sense to Federal Procurement*, April 15, 2025.

Results and Recommendations

Finding 1: Contracted CBOC Program Lacked Effective Oversight

VHA's national program offices did not effectively manage or oversee the full life cycle of CBOC contracts. Program office oversight ended once contracting officers awarded a contract, leaving VHA without a headquarters-level office to oversee the effectiveness of the contracts for the remainder of their life cycle. Furthermore, VHA issued policies to govern healthcare resources contracts, including CBOC contracts, that did not incorporate all responsibilities required of a VHA program office. This limited the offices' ability to identify and implement solutions for national issues, which may have adversely affected the care provided to veterans and created administrative challenges for VA medical centers and contracting offices. These issues may also have contributed to contracted CBOCs providing healthcare services that scored below VHA's overall performance metrics, wasted resources, and created barriers to competition.

What the OIG Did

The audit team reviewed applicable VHA policies, procedures, and directives to understand the roles and responsibilities for oversight of contracted CBOCs. The team also interviewed officials from the Office of Primary Care, MSO, and the VHA Acquisitions Office to verify that these policies had been implemented.

As of December 2023, VHA had 92 contracts for 107 CBOC locations, initially valued at about \$2 billion with an objective to serve an initial estimated 283,700 patients. The team created a sample universe of the contracts that had an effective date of January 2023 or earlier and expired no earlier than July 2024; the sample universe included 56 contracts for 67 CBOC facilities. To ensure sufficient performance data for comparison, the team excluded contracts that had less than a year of performance as of January 2024; the team also excluded contracts that expired before July 20, 2024, to minimize reporting on contracts that were no longer active.

To evaluate the effectiveness of program office oversight, the audit team selected a statistical sample of 11 contracts for 19 CBOC locations with performance data from January 2023 through July 2024. The audit team obtained and analyzed contract documentation, including performance reviews, and interviewed contractors, contracting officers, and CORs who oversaw the contractors. See appendix A for full details on this audit's scope and methodology.

VHA's Program Office Oversight

While the Office of Primary Care and MSO are both program offices that have responsibilities for CBOC contracts, neither office provided governance or oversaw the life cycle of the CBOC contracts after they were awarded, as required by VA and VHA policies.

In March 2024, VA established the Acquisition Life Cycle Framework, which is intended to improve governance of national programs.²¹ The framework highlights the importance of program offices managing all aspects of their program’s life cycle from planning through contract award, performance, and closeout. It also focuses on improving program and acquisition life cycle actions, including better governance of programs to increase the likelihood of mission success.

Additionally, VHA Directive 1217 enables clear, sustainable, and repeatable governance processes that support robust oversight and management of VHA activities.²² It defines governance as the process by which senior leaders make decisions, provide strategic direction, and maintain accountability to enable informed decision-making, and it stipulates that national programs must be managed by program offices. VHA program offices are described in the directive as main operating units of VHA’s central office that develop policies and strategies and provide tools to the field in support of national goals. Specifically, these offices are responsible for

- governance, including providing systemic oversight, developing training, and setting standards;
- expertise, including serving as subject-matter and technical experts for their programs; identifying emerging national issues; adopting evidence-based strategies; and developing and publishing regulations, policies, and guidance;
- leadership, including communicating with internal and external stakeholders on a national level to facilitate addressing issues identified by local offices; and
- oversight, including managing quality, compliance, and risk; setting quality and performance measures; evaluating the effectiveness and efficiency of outcomes; assessing the accuracy of data used for evaluation; overseeing consistent implementation; and documenting all identified deficiencies.

The OIG team found that, despite these requirements, VHA has published multiple policies for contracted CBOCs that do not incorporate all responsibilities required of a VHA program office. VHA has issued multiple policies that define MSO as the program office responsible for developing guidance and training and for overseeing the authority to acquire healthcare resources, specifically

- VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office*, February 21, 2023;

²¹ VA Notice 24-08, “Establishment of the Veterans Affairs Acquisition Lifecycle Framework,” March 8, 2024.

²² VHA Directive 1217. This directive was updated on August 14, 2024. Based on the scope of the audit, the team relied on the 2021 version for analysis; however, the updated version did not change program office requirements.

- VHA Procurement Manual, part 873; and
- VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Title 38 U.S.C. § 8153*, May 10, 2018.

These policies outline MSO’s responsibility to provide administrative oversight and guidance when VA medical centers buy services using healthcare resource contracts, which include CBOC contracts.²³ MSO is further required in these policies to ensure the mandatory use of contract requirements templates, to conduct reviews to ensure compliance with statutory requirements, and to publish guidance for healthcare resource contracts. In collaboration with the Office of Primary Care and the Office of General Counsel, MSO is also responsible for conducting, processing, and approving procurement reviews for healthcare resource contracts before they are awarded.²⁴ However, based on these policies, MSO’s responsibility ends once the contracts are awarded.

Officials in the VHA Office of Acquisitions and MSO told the OIG team in interviews that VA medical centers and network contracting offices are responsible for managing and overseeing the CBOC operations in their healthcare systems. However, by requiring the VA medical centers and network contracting offices to manage and oversee the CBOC contracts, VHA did not have a headquarters-level office managing or overseeing the quality or effectiveness of the contracted CBOCs to enable informed decision-making or to increase the likelihood of the program fulfilling its mission. VHA should update the governance policies for contracted CBOCs to ensure program offices comply with all program office requirements defined in VHA Directive 1217.

Performance and Administrative Challenges

The lack of oversight and effective program management limited the ability of MSO and the Office of Primary Care to identify and implement solutions for national problems that may have affected care and created administrative challenges for VA medical centers and contracting offices. Specifically, contractors consistently did not meet contract performance requirements, start-up costs created barriers to competition, and medical centers and contracting offices experienced persistent administrative challenges with creating and maintaining billable rosters, appointing qualified CORs, and connecting new CBOCs to the VA network.²⁵

²³ VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office*, February 21, 2023; VHA Procurement Manual, part 873.

²⁴ VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Title 38 U.S.C. § 8153*, May 10, 2018; VHA Procurement Manual, part 873.

²⁵ Billable rosters are monthly lists of assigned patients that the contractor can submit invoices for based on the contract rates.

Contract Performance Metrics

According to a VHA directive, the contracted CBOCs must provide consistent, safe, and high-quality care in accordance with VHA policies and performance requirements.²⁶ To ensure contractors abide by policies and meet requirements, the FAR requires agencies to develop performance metrics that are measurable, reasonable, attainable, and designed to enable oversight officials to assess a contractor's performance.²⁷ However, CBOC contractors consistently did not meet performance metrics and CORs regularly did not evaluate all metrics—two deficiencies that could affect the care provided to veterans at the CBOCs.

As mentioned, the audit team sampled 11 contracts for 19 CBOC facilities. The contracts generally included 20 to 22 performance metrics based on VHA's performance standards for providing high-quality care.²⁸ Based on available COR performance reviews, the contractors for these 19 facilities did not meet 56 percent of the performance metrics on average. Specifically, these sampled contractors consistently did not meet 14 of the 22 performance metrics, which included the seven performance metrics related to access to care. Additionally, the contractors did not meet six of the 14 metrics more than 75 percent of the time, including metrics for care-team staffing, same-day appointments, appointment cancellations, and documentation for patient visits. The contractors consistently met only five of the 22 performance metrics. Figure 2 summarizes the audit team's analysis of the sampled contractors' compliance with the performance metrics based on COR performance reviews.

²⁶ VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, amended October 4, 2019.

²⁷ FAR 16.401 and 37.6. Updated in RFO FAR 16.401-1 and 37.102-1.

²⁸ The 22 performance metrics were broken into seven broad categories: access to care, quality of care, panel management, veteran satisfaction, coordination of care, environment of care, and pharmacy.

Domain	Performance metric	Percent met	Percent not met	Percent not rated	Consistently met (greater than 50%)
Access to care	Appointment cancellations	4%	89%	6%	✘
	Same-day appointments with primary care provider	19%	81%	0%	✘
	Established patient average wait time within 20 days	34%	66%	0%	✘
	New patient appointments completed within 20 days	35%	63%	2%	✘
	Patient survey results for overall access to care questions	37%	55%	7%	✘
	Patient survey results for patient appointment wait times	27%	54%	19%	✘
	Primary care mental health intervention	46%	54%	0%	✘
Quality of care	Composite – prevention	6%	90%	4%	✘
	Progress notes and patient care encounter documentation	6%	80%	14%	✘
	Composite – cardiovascular risk management	53%	42%	5%	✔
	Composite – tobacco	46%	37%	17%	⊖
	Composite – behavioral health screening	63%	21%	16%	✔
Panel management	Clinical reminders	0%	12%	88%	✘
	Contractor staffing of healthcare teams	15%	85%	0%	✘
	Percent of primary care patients enrolled in home telehealth	10%	81%	9%	✘
	Ratio of nontraditional encounters	37%	63%	0%	✘
	Percent of women assigned to women's health team or designated women's health provider	57%	34%	9%	✔
Veteran satisfaction	Veteran satisfaction	38%	54%	8%	✘
Coordination of care	Contact by care team after discharge	40%	59%	1%	✘
Environment of care	Percent of deficiencies identified during environment of care rounds that are closed timely	49%	0%	51%	✘
Pharmacy	Clinical pharmacy specialist use of pharmacy database	54%	32%	14%	✔
	Medication storage area inspections	75%	5%	20%	✔

Yes
 No
 Scores did not exceed 50 percent for any category

Figure 2. Summary scores for the 22 performance metrics.

Source: VA OIG analysis of COR oversight reports for sampled contracts.

Note: Percentages for some performance metrics do not sum precisely due to rounding.

Of note, the CORs did not always rate contractors for all metrics, leaving forms blank or noting that they could not find the required information to evaluate the metric or that they believed an audit of the data was required to verify its accuracy. In particular, CORs consistently did not rate the contractors for two performance metrics: clinical reminders and closure of deficiencies identified during environment of care reviews.²⁹

The 19 sampled CBOCs consistently scored lower than VHA's national average for the same performance metrics. The audit team reviewed results for six performance metrics that program office officials and CORs said were the most important.³⁰ The sampled CBOCs scored lower than the VHA average for five of the six healthcare performance metrics reviewed. Sampled CBOCs performed better than the national average only for the metric related to how quickly the contracted CBOCs completed new patient appointments.

By not monitoring or overseeing the effectiveness of the contracts after they were awarded, the program offices limited their ability to identify issues and take corrective action when contractors consistently did not meet the performance metrics. Further, when CORs identified challenges with evaluating the contractors, the program offices were not engaged to help find solutions. The program offices should develop and implement procedures to monitor overall compliance with contract requirements and use the results to reassess program policies and contract requirements for contracted CBOCs. In addition, the program offices should reevaluate whether the CBOC contract performance metrics are measurable, reasonable, and attainable.

Start-Up Costs

The method for reimbursing contractors for CBOC start-up costs, including the considerable construction costs associated with preparing a facility to see patients, creates a barrier for promoting and maintaining competition in the CBOC program. The federal government is required to promote full and open competition when awarding government contracts, with limited exceptions.³¹

Before a CBOC opens for operation, contractors are required to acquire, renovate, and furnish a facility and to hire, train, and credential staff. The start-up time depends on the contract but typically lasts from three to six months. CBOC contractor officials explained that construction costs range from \$1 million to \$10 million per clinic.

²⁹ Clinical reminders are generated by the health record and the contractor is required to complete and document all reminders during a patient's visit. Environment of care reviews evaluate the safety, security, and health environment of the facility in accordance with national and VHA standards.

³⁰ The audit team compared the contracted CBOC performance metrics to VHA's national average scores for new- and established-patient appointments within 20 days, same-day appointments, appointment cancellations, care-team staffing, and primary care mental health integration.

³¹ FAR 6.1. Updated in RFO FAR 6.101.

The OIG team found that the contract requirements template did not allow contracting officers to pay start-up costs as a separate contract line item.³² Instead, the template included a single payment model, referred to as a per-member-per-month rate, that paid a contractor based on how many patients are assigned to be seen at the clinic. Consequently, contractors did not get paid until the medical center assigned patients at the CBOC after the start-up period ended and the clinic opened for operation.

To recoup start-up costs, contractors incorporated the construction costs into their per-member-per-month rates. While each contractor calculates its rate differently, they generally add all their estimated costs, including construction costs, then divide by the estimated number of patients, and then by the number of months.³³ The contractors therefore spread the start-up costs across several months or several years, sometimes up to 10 years. Because contractors were not paid for start-up costs for up to 10 years, they were typically compelled to borrow money and pay interest on loans to cover construction costs. Contractors passed on the cost of this interest to VHA through higher rates for services to veterans—resulting in VHA paying more for CBOC services.

Contractor officials told the OIG team that having to pay start-up costs at the beginning of a contract prevented them from bidding on additional contracts and that it may be difficult for small businesses to acquire the loans necessary to pay construction costs for a contracted CBOC. Moreover, VA's Office of General Counsel noted that CBOC contracts were at a high risk for contract protests based on a protest that alleged the payment method for CBOC start-up costs unduly restricted competition. Contractors can protest contract solicitations or awards they believe violate statutes or contract regulations; protests are submitted to the Government Accountability Office, which reviews all documentation and then makes a ruling with recommendations to the contracting agency. According to VA's Office of General Counsel, based on the protests, the Government Accountability Office agreed that the method of reimbursing start-up costs unduly restricted competition and informed VA it would sustain a contract protest based on these concerns.

With only one contract line item, a contractor may not recoup its start-up costs and may lose money if the CBOC does not reach the estimated number of assigned patients that the contractor used to build its rates. MSO officials explained that although large, experienced businesses had worked out how to use the payment model, new companies may incur a loss the first time they attempt to provide CBOC services. The following examples are instances of CBOCs that did not receive the estimated number of patients in the first year of the contract.

³² MSO published an updated contract requirements template in April 2024 that included instructions for contracting offices to allow offerors the chance to submit alternative pricing proposals to account for construction costs. However, VHA used only a single contract payment unless contractors proposed alternative pricing.

³³ Total costs include salaries, office and medical equipment, rent, and utilities.

Example 1

The VA central Texas healthcare system estimated that the contracted CBOC in Copperas Cove, Texas, would have 4,700 patients assigned per month—but according to the contracting officer, in the first month the medical center assigned only seven patients at the CBOC. In the second month, enrollment increased to just 25 patients. The contracting officer and COR said that by the end of the first year, only 1,000 patients were assigned (21.3 percent of expected assignments).

Example 2

The Loma Linda healthcare system awarded a contract for five CBOC locations. At the end of the first year, the healthcare system assigned only 71.7 percent of the estimated patients across all five contracted clinics, which contractor officials said contributed to a substantial loss. For instance, the contract estimated that one of the five locations, in Palm Desert, California, would see 7,577 patients per month, but it had assigned only 5,851 patients by the third month of the contract (77.2 percent).

In April 2024, MSO published an updated contract requirements template, providing instructions to contracting offices and saying contractors could submit alternative pricing proposals to account for start-up costs, which may result in a separate contract line item to pay for the construction costs. However, MSO did not make the separate contract line item a standard practice, and as of April 29, 2025, VHA had not awarded any contracts with a separate line item. Instead, the updated template only provided instructions for contracting offices to consider alternative pricing if a contractor proposed it. Consequently, contract solicitations issued using the revised template did not notify contractors that they could submit alternative pricing options to recoup construction costs.

By not paying start-up costs as a separate contract line item that VHA could pay throughout the start-up period, VHA unnecessarily restricted competition and prevented some companies from bidding on contracts. VHA also increased its own costs, as contractors added the cost of their construction loan interest into their rates. While program office staff took some actions to mitigate barriers to competition, MSO should update the contracted CBOC procedures to consider a standard separate payment for contract start-up costs.

Billable Rosters

Program offices are required to evaluate the effectiveness of outcomes and the efficiency of outputs, including assessing the accuracy of data used for evaluation.³⁴ However, an official from the Office of Primary Care said that CORs were not required to use consistent procedures to generate billable rosters, which contributed to the significant administrative burden that these rosters caused. Because contractors are paid based on fixed per-member-per-month rates for each patient assigned to the clinic, the accuracy of a billable roster is critical to determine how many patients are assigned to the contracted CBOC. For patients to remain on the billable roster, they must receive one qualifying doctor appointment within a 12-month period, must not have moved or passed away, and must not have been referred to receive primary care services elsewhere.

Although patients are assigned at contracted CBOCs using a VA database, the database cannot generate a billable patient roster that is consistent with the contract requirements; therefore, the CORs had to manually create and maintain the rosters. CORs explained that the database cannot identify whether CBOC patients have had the one required qualifying appointment within a 12-month period; it generates reports based on qualifying appointments only within the last 18 months. The CORs therefore had to manually identify duplicate patients and determine which patients needed to be removed from the roster for not having had a qualifying appointment within 12 months. An Office of Primary Care official acknowledged that the system-generated report requires manual review and removal of patients. Because the database cannot generate a suitable report, each COR developed a different procedure to create and track the billable roster, and CORs said the billable roster took a significant amount of time to maintain. Therefore, the program offices should assess how medical centers create and maintain billable rosters then develop and require efficient, accurate, and consistent procedures for maintaining them.

COR Certifications

Because program offices did not systemically manage program risk in coordination with the Veterans Integrated Services Networks, they could not ensure medical centers and contracting officers nominated and appointed sufficiently certified CORs to oversee CBOC contracts.³⁵ CORs can obtain three certification levels, each enabling them to oversee contracts of increasing complexity. A VA handbook suggests that CORs with level I certification can oversee low-risk contracts valued up to \$1 million; level II certified CORs can oversee more complex contracts valued from over \$1 million to \$7 million; and level III certified CORs should be assigned to

³⁴ VHA Directive 1217.

³⁵ VHA divides the United States into 18 regional networks that manage day-to-day functions of medical centers and provide administrative and clinical oversight.

highly complex contracts valued at more than \$5 million.³⁶ All 11 contracts the OIG team sampled exceeded \$5 million.

In February 2022, VHA published supplemental guidance for COR certification levels, removing the suggested contract dollar thresholds for each certification level of oversight. Instead, VHA directed contracting officers to an Office of Federal Procurement Policy memorandum to determine the appropriate COR certification level required for their contract.³⁷ The criteria in the policy memorandum do not provide a clear distinction between contract risks that would require level II and level III certified CORs.³⁸ Based on the audit team’s interpretation of the memorandum, the CORs for the CBOC contracts could have been certified at level II or III. However, according to the overarching VA handbook, the CORs should have been level III certified.³⁹

The CORs for CBOC contracts have several responsibilities. They process and monitor contractor employee on-boarding; monitor the contractor’s performance using several VHA databases; communicate with the contracting officer, facility, and contractor; maintain the billable roster; and review and approve invoices. Accordingly, contracting officers, CORs, and contractors said the complexities of the CBOC contracts require a full-time, experienced COR. However, although all the sampled contracts were valued over \$5 million, only one contract had a level III COR assigned. Contracting officers appointed level I–certified CORs to oversee three of the contracts and appointed level II–certified CORs to oversee six of the contracts. Table 1 lists the COR certification levels for each sampled contract.

Table 1. COR Certifications for Sampled Contracts

CBOC location	Original estimated total contract value at award	COR certification level
West Palm Beach	\$232.6 million	Level II
Loma Linda	\$123.7 million	Level III
Danville	\$81.6 million	Level II
Braunfels*	\$80.5 million	Level I
Copperas Cove	\$64.1 million	Level II

³⁶ VA Handbook 7403, *Federal Acquisition Certification for Contracting Officer’s Representatives (FAC-COR) Program*, August 23, 2018.

³⁷ VHA Procurement Guide part 801-603-70, effective February 1, 2022, and updated May 1, 2025, as VHA Procurement Guide part 801.604-70. The update did not change the COR certification level criteria.

³⁸ Office of Federal Procurement Policy memorandum, “Revisions to the Federal Acquisition Certification for Contracting Officer’s Representatives (FAC-COR),” memorandum to chief acquisition officers and senior procurement executives, September 6, 2011.

³⁹ VA Handbook 7403.

CBOC location	Original estimated total contract value at award	COR certification level
Jefferson County	\$39.5 million	Level II
Plattsburgh	\$26.7 million	Level I
Tompkins County	\$25.0 million	Level II
Oswego	\$19.9 million	Level II
Bogalusa [‡]	\$15.4 million	Not available
McComb	\$7.9 million	Level I

Source: VA OIG analysis of COR certifications.

Note: Dollar values are rounded.

*The contracting officer for the Braunfels contract appointed the COR in July 2023. The COR achieved level II certification in July 2024.

[‡]The Bogalusa CBOC contract was awarded in March 2022, but the COR was not formally appointed by the contracting officer until September 2024 and did not obtain a COR certification level until March 2025.

Program office officials said they did not monitor whether CORs had the appropriate certification levels to oversee CBOC contracts. Therefore, MSO should work with the medical centers to conduct a risk assessment of the responsibilities and time requirements to oversee CBOC contracts and publish clear guidance to help medical centers nominate CORs who have the necessary training, experience, and certification level. VHA’s Office of Acquisitions should also develop procedures to assess the qualification levels of the CORs assigned to CBOC contracts and make recommendations to the medical centers for assigning appropriately experienced CORs or provide any additional training or assistance to existing CORs if necessary.

Information Technology Delays

The CORs for seven of the 11 CBOC contracts the OIG team sampled said the CBOCs they oversaw experienced delays connecting to VA’s phone network—and that these facilities were open and providing clinical care despite not having working phones. The CORs and contracting officials said delays with installing and connecting phone lines prevented patients from contacting the CBOCs and prevented CBOC staff from calling 911 from the CBOC phone system. The contract requirements template says VA medical centers are required to provide CBOC contractors with information technology equipment, such as computers, software, telecommunications lines, and networking equipment, that is needed to connect to VA’s systems. In one instance, VA did not connect the phone service for almost two years after the clinic opened for operation, leading to several patient complaints. Instead, the medical centers and contractors used workarounds, such as relying on government-issued cell phones or, in one case, requesting that the contractor provide temporary phone service at no extra cost to the

government. The CORs explained that without working phones at the clinics, they experienced significant administrative challenges in ensuring the clinics remained operational.

Had the program offices regularly communicated with internal and external stakeholders to identify emerging nationwide problems, they could have identified the persistent network and phone deficiencies. The program offices should coordinate with the Office of Information and Technology to verify it can meet start-up requirements for new CBOCs. Furthermore, the offices should document national challenges and communicate them to contracting offices and medical centers to reduce the administrative burden of CBOCs having to create their own solutions to systemic issues.

Finding 1 Conclusion

National programs must be managed by program offices, which have specific responsibilities intended to assure effectiveness and quality. By ending program office oversight responsibilities once CBOC contracts were awarded, the MSO national program office left VHA without a headquarters-level office to manage quality and compliance, evaluate effectiveness, or identify and mitigate national issues that affected the contracted CBOCs the OIG team reviewed. Consequently, the contracted CBOCs encountered significant performance challenges and administrative burdens that prevented them from achieving the goal of providing high-quality, cost-effective primary care to veterans. Until VHA requires a headquarters-level office to appropriately oversee the contracted CBOCs in accordance with VHA program office policies, CBOC contracts will continue to face performance and administrative challenges that may prevent the CBOCs from providing the level of high-quality care that veterans deserve.

Recommendations 1–9

The OIG made the following recommendations to the under secretary for health and the VHA chief operating officer:

1. Review and update VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office*, to delegate all required program office responsibilities for the community-based outpatient clinic contracts throughout the program's life cycle to an appropriate headquarters-level office or collaboration of offices, as defined in VHA Directive 1217, *VHA Operating Units*.
2. Develop and implement procedures for a headquarters-level office to monitor overall compliance with contract requirements and use the results to reassess program policies or contract requirements.
3. Develop a formal feedback process, such as a program life cycle review process, for contracting officers and contracting officer's representatives, medical facilities, and contractors who work on community-based outpatient clinic contracts to provide

lessons learned, issues encountered, and other feedback about establishing new clinics and the performance at the clinics.

4. Assess contractor compliance with all active community-based outpatient clinic contracts, then evaluate whether the community-based outpatient clinic contract performance metrics are measurable, reasonable, and attainable.
5. Coordinate with the Office of General Counsel to determine whether creating a separate contract line item from the operational costs for contracted community-based outpatient clinics to pay start-up costs, including construction costs, would help in the administration of these contracts and increase competition among contractors then update the community-based outpatient clinic performance work statement template to reflect any changes made as a result of this consideration.
6. Assess how medical centers create and maintain the billable roster for community-based outpatient clinic contracts and, based on the results, develop and implement efficient, accurate, and consistent procedures for creating and maintaining the billable rosters.
7. Coordinate with the VA medical centers that have VA-contracted community-based outpatient clinics to conduct a risk assessment to evaluate the responsibilities, time requirements, and qualifications of community-based outpatient clinic contracting officer's representatives, then publish clear guidance or recommendations for facilities to make sure they have appropriately experienced, trained, and certified staff to oversee the performance of community-based outpatient clinic contracts.
8. Assess the certification levels of the CORs assigned to all CBOC contracts and make recommendations to the medical centers for assigning appropriately experienced CORs or to provide any additional training or assistance to existing CORs, if necessary.
9. Develop and implement procedures to require VA medical centers and contracting offices to verify that the Office of Information Technology can meet start-up requirements for new community-based outpatient clinic locations as part of the contract review process.

VA Management Comments

On November 3, 2025, the former acting under secretary for health concurred with recommendations 5 and 6, and concurred in principle with recommendations 1–4 and 7–9. On February 10, 2026, the current under secretary of health advised that he is forming a work group to assess and standardize the process for CBOC contract oversight based on this OIG report. He

said the results of the work group may change the action plans previously provided by the former acting under secretary.

VHA's proposed actions to address each recommendation are summarized below, and the full text of the former acting under secretary's response is in appendix B.

- **Recommendation 1.** The former acting under secretary for health said the VHA Chief Office of Operations agreed that VHA Directive 1660.07 should be updated to reflect pending changes to VHA's organizational structure and to clarify responsibilities of the MSO within the new structure. In addition, the Chief Office of Operations plans to create a work group—consisting of Office of Acquisitions contracting subject matter experts, additional relevant national program offices, Veterans Integrated Service Network leaders, and designated contracting officer's representatives—to review VHA Directive 1229(1) to ensure it assigns all responsibilities required by VHA Directive 1217 to the appropriate office(s).
- **Recommendation 2.** The former acting under secretary for health noted that procedures for monitoring overall compliance with contract requirements already exist and a single headquarters office does not monitor the overall compliance of all CBOC contracts. Therefore, the Chief Office of Operations work group plans to assess program policies and contract requirements. The former acting under secretary also noted that CBOC standards apply to both VA-operated and contractor-operated CBOCs.
- **Recommendation 3.** The former acting under secretary for health said a feedback process exists and the Chief Office of Operations work group plans to review current feedback processes and make recommendations for updates.
- **Recommendation 4.** The former acting under secretary for health said the Chief Office of Operations work group plans to assess existing contractor performance results to ensure the metrics are measurable, reasonable, and attainable.
- **Recommendation 5.** The former acting under secretary for health said MSO plans to re-engage the Office of General Counsel regarding a separate contract line item for start-up costs.
- **Recommendation 6.** The former acting under secretary for health said the Chief Office of Operations work group plans to assess the state of billable roster creation and maintenance and, based on the results, make recommendations to improve the accuracy and efficiency of the process.
- **Recommendation 7.** The former acting under secretary for health said the Chief Office of Operations work group plans to notify the VHA Office of Acquisitions if

the current COR guidance should be revised after the completion of the risk assessment.

- **Recommendation 8.** The former acting under secretary for health said the VHA Office of Acquisitions plans to assess the certification levels of CORs assigned to all current CBOC contracts. Any results from this assessment are to be shared with the medical centers, as necessary. The medical centers will then determine whether a new COR should be assigned or whether an existing COR requires additional training.
- **Recommendation 9.** The former acting under secretary for health said the Office of Information and Technology should be included in facility planning teams for CBOCs to ensure start-up requirements can be met. The former acting under secretary for health further said the Chief Office of Operations work group plans to evaluate Information and Technology’s involvement in planning teams and develop recommendations for their involvement.

OIG Response

The comments and corrective actions from the former acting under secretary for health are responsive and meet the intent of recommendations 1 and 3–9.

The comments and corrective actions for recommendation 2 were only partially responsive because the former acting under secretary noted that procedures to monitor overall compliance with contract requirements already exist and that CBOC standards apply to both VA-operated and contractor-operated CBOCs. However, VHA created policies, procedures, and templates specifically for contracted CBOCs. Without a headquarters-level office to monitor the effectiveness of the contracted CBOCs and the templates, VHA limits its ability to identify and take corrective action when contractors consistently do not meet performance metrics. Therefore, to meet the intent of recommendation 2, the work group that VHA proposed should identify a headquarters-level office or a collaboration of offices to monitor the effectiveness of both the contracted CBOCs and contractor performance and make any needed adjustments to the contract templates.

The OIG will monitor implementation of the planned actions and will close the recommendations when the under secretary provides evidence demonstrating sufficient progress in addressing the issues identified.

Finding 2: CBOC Contracts Did Not Motivate Contractors to Perform or Enable Accountability

VHA's program offices required contracting officers to use a contract template for CBOC contracts. But the template did not enable contracting officers to motivate contractors to meet or exceed required performance metrics or hold them accountable when metrics were not met. This occurred in part because VHA procurement officials stopped including performance incentives in contracts based on an interpretation of guidance from VA's Office of General Counsel.⁴⁰ However, federal acquisition policies require agencies to consider including performance incentives in contracts for services "to the maximum extent practicable" to motivate contractors to meet or exceed desired performance.

Without effective means to hold contractors accountable, contracting officers and VA medical centers accepted performance that did not meet contract requirements. Specifically, the contractors for the 11 contracts the OIG team sampled did not meet 56 percent of the contract performance metrics, on average, from January 2022 through March 2024. Although the contractors underperformed, they still received full payment for the patients assigned to their clinics.

What the OIG Did

To understand the procedures for accepting contracted CBOC services, paying contractors, reporting contractor performance, and using available tools to motivate underperforming contractors, the audit team reviewed applicable criteria including the FAR, modifications to the FAR from the RFO FAR initiative, and an Office of Federal Procurement Policy memorandum. The audit team reviewed and analyzed multiple versions of the CBOC contract requirements template, the 11 sampled contracts, and the results of contractor performance reviews conducted by the CORs. The team evaluated how VHA changed the performance metrics and tools to ensure contractor accountability from 2016 through 2024 and interviewed officials from the program offices, VA's Office of General Counsel, contracting offices, contractors, and the Centers for Medicare & Medicaid Services (CMS). Also, the team researched commercial contract arrangements that were similar to the CBOC contracts, including reviewing CMS's available payment plans and medical studies on similar payment plans.

⁴⁰ VA Office of General Counsel guidance, Service Area Office Central, Volume 6, Issue 2, "Legal Corner Making Sense of Liquidated Damages and Disincentives," February 2017.

Contracting Officer Options to Hold Contractors Accountable

The contract requirements template defines the contract payment structure and performance metrics contractors must meet to comply with each contract.⁴¹ The template includes a payment structure that pays the contractor a fixed price per patient assigned per month and includes 22 performance metrics.⁴² The template also includes additional contract requirements and provisions to increase consistency among contracted CBOCs, but it does not include language to motivate or hold contractors accountable.

Without options available in the contract template, contracting officers were limited in how they could hold contractors accountable for meeting contract requirements. Contracting officers could increase oversight and communication with contractors about noncompliance, issue notices of noncompliance, not exercise option years, terminate contracts, or document a lower performance rating in the federal contractor performance system—all of which are methods supported by the FAR.⁴³ However, based on interviews with multiple contracting officers who oversaw CBOC contracts and based on the OIG team’s analysis, each of these options has drawbacks related to time, resources, and the complexities of the CBOC contracts.

Increase Oversight

Contracting officers and CORs could attempt to increase oversight and discuss performance challenges more frequently with contractors to attempt to improve performance. A contracting officer said more frequent monitoring and feedback from the COR could enable contractors to address deficiencies expeditiously before they became a greater concern. However, CORs may not have the time or resources to provide greater oversight and communication for every contract in addition to fulfilling their other responsibilities, as the CORs for contracted CBOCs oversaw multiple contracts. In addition, increasing oversight and communication might not have a direct effect on contractor performance; for example, talking to a contractor more often may not compel them to hire more staff.

Issue Notices of Noncompliance

Contracting officers can issue notices of noncompliance and require contractors to submit corrective action plans to improve performance and ensure future performance complies with

⁴¹ VHA Procurement Manual, part 873.

⁴² The CBOC contract requirements template was updated in April 2024 to include 34 performance metrics.

⁴³ The federal contractor performance system is called the “Contractor Performance Assessment Repository System.”

requirements.⁴⁴ Most contracting officers and CORs for the sampled contracts said they had issued notices of noncompliance to the CBOC contractors to improve performance. However, when contractors were still not meeting performance metrics despite the notices, the contracting officers did not take additional actions permitted by the FAR. For example, a contracting officer explained that reducing payment for services that did not comply with a contract—one of the options available in the FAR—may exacerbate the problem because it could result in the contractor providing even fewer services. Contracted CBOCs often serve veteran populations in areas that are rural or otherwise far from VA medical centers. Accordingly, contracting officers said any decisions to cut payments to contracted CBOCs have to be weighed against the possibility that services and medical care for veterans in need could also be reduced. Contracting officers and CORs told the OIG team that most performance concerns were related to insufficient contractor staff and that reducing payment may result in a further decrease in staffing. Therefore, while issuing notices of noncompliance is an option for motivating contractors to perform better, it may not result in improvement if contracting officers do not hold the contractor accountable for implementing corrective actions.

End the Contract

Contracting officers could choose to terminate a contract or to not exercise contract option years because of poor performance.⁴⁵ A contracting officer explained that terminating CBOC contracts is not in the best interest of VHA and the veterans served and should be used as a last resort after all other options are exhausted. Another contracting officer said medical facility and community care resources could not absorb CBOC patients, so terminating a contract could adversely affect patient safety and care. In particular, contracting officials said planning and awarding new CBOC contracts takes between one and two years (or longer); therefore, if a medical facility has not started planning for a new contract before terminating an existing one, the CBOC's patients could lose access to care for an extended period. Officials from multiple locations told the audit team that the long-term goal of their medical centers was to phase out the contracted CBOCs and convert them to VA-operated CBOCs. However, as previously noted, it can take years to establish VA-operated CBOCs. Unless a medical facility and its contracting office already have plans in place to provide care for patients, terminating contracts or not exercising contract option

⁴⁴ FAR 52.246-4. The FAR states that if the contractor does not comply with the contract requirements and it cannot perform the services to comply, then the government can require the contractor to take necessary action to ensure future performance complies and can reduce the contract price to reflect the reduced value of the services performed. If the contractor does not improve its future performance to conform with contract requirements, then the government can perform the required services and charge the contractor for any incurred costs or terminate the contract.

⁴⁵ CBOC contracts generally include a base period and multiple options to extend the contract for several years. Upon completion of the base period, the government evaluates whether the services provided are still needed before exercising a prenegotiated option year to extend the contracted services for a set period.

years because of a contractor’s poor performance could mean patients will lose access to care they need.

Lower Performance Ratings

Another option to hold contractors accountable for performance is entering lower ratings for the contractor in the federal contractor performance system, Contractor Performance Assessment Reporting System (CPARS). CPARS is the governmentwide official source for contractor performance information and is used when evaluating proposals from prospective contractors for a new government contract.⁴⁶ CPARS documents contractor performance for several categories including technical quality of service, cost control, schedule or timeliness, management or business relations, and small business subcontracting. In CPARS, agencies can rate contractors as exceptional, very good, satisfactory, marginal, or unsatisfactory—with satisfactory indicating the contractor met the requirements of the contract without any significant weaknesses. See table 2 for details on the CPARS ratings.

Table 2. CPARS Ratings

Rating	Definition
Exceptional	Performance exceeds many contractual requirements to the government’s benefit. Few minor problems occurred, and corrective actions were highly effective.
Very Good	Performance exceeds some contractual requirements to the government’s benefit. Some minor problems occurred, but corrective actions were effective.
Satisfactory	Performance meets contractual requirements. Some minor problems occurred, but corrective actions were satisfactory. No significant weaknesses were identified.
Marginal	Performance does not meet some contractual requirements. Performance reflects a serious problem, and the contractor has not yet identified corrective actions, the corrective actions were only marginally effective, or they were not fully implemented.
Unsatisfactory	Performance does not meet most contractual requirements, and recovery is not likely to occur in a timely manner. Performance has a serious problem, and corrective actions were ineffective.

Source: Definitions adapted from FAR 42.15. Updated in RFO FAR 42.11.

A lower rating in CPARS could affect a contractor’s ability to win new contracts. Because it is used when awarding contracts, CPARS is a valuable tool for contracting staff to motivate contractor performance, as contractors want satisfactory or better ratings to improve their competitiveness for future contracts. However, if contracting officers do not accurately report

⁴⁶ FAR 42.15. Updated in RFO FAR 42.11.

contractor performance, then CPARS ratings lose their effectiveness for holding contractors accountable.

Contracting officers for the CBOC contracts did not always rate the contractors in the CPARS system accurately based on their contractual performance. Specifically, contracting officers for 10 of 11 sampled contracts rated the contractors with satisfactory or very good CPARS ratings; however, when questioned by the OIG team, contracting officers could not justify why they awarded those ratings when the contractors' performance did not meet several metrics and corrective actions did not improve performance. Based on the CPARS rating definitions, if contractors did not meet several performance metrics and their corrective actions were only marginally effective or not implemented, the contractors should have received marginal ratings. Several contracting officers and CORs said they encountered challenges assessing CPARS ratings for the five broad rating categories, which did not correlate with the 22 contractual performance metrics; they said this made it difficult to determine how to rate the contractors.

Because VHA contracting officers did not rate all contractors accurately, the program offices should evaluate the accuracy and completeness of CPARS ratings for CBOC contracts and provide additional guidance on how to translate the 22 performance metrics into the five broad CPARS performance categories.

Performance Incentives Not Used

Federal acquisition policies require agencies to consider including performance incentives in contracts for services "to the maximum extent practicable."⁴⁷ Performance incentives can motivate quality contractor performance with either positive or negative incentives connected to measurable tasks that relate profit or fees to the contractor's results. Performance incentives are widely used in the commercial market for contracts similar to CBOC contracts. However, the OIG team found that VHA procurement officials removed performance incentives from CBOC contracts in 2017 based on an interpretation of guidance from the VA Office of General Counsel.

Performance Incentives

When quality performance is critical and performance incentives are likely to motivate a contractor, acquisition policies encourage agencies to consider both positive and negative performance incentives for contracts, "to the maximum extent practicable."⁴⁸ CBOC contracts are healthcare resource contracts awarded in accordance with a federal law that requires agencies to award such contracts as commercial services using firm-fixed-price contracts.⁴⁹

⁴⁷ FAR 16.402-2. Updated in RFO FAR 16.403-2.

⁴⁸ FAR 16.402-2. Updated in RFO FAR 16.403-2.

⁴⁹ 38 U.S.C. § 8153.

The FAR says firm-fixed-price contracts can include performance incentives when they are based solely on factors other than cost, such as performance. The regulation further states that firm-fixed-price contracts that include performance incentives would remain firm-fixed-price contracts.⁵⁰ Meanwhile, the Office of Federal Procurement Policy says using performance incentives appropriately is vital to achieving mission needs, minimizing waste, and maximizing value to the government.⁵¹ They are suitable for use in procurements where the government would like to provide a contractor with a financial reward for surpassing performance targets while also having the option to penalize the contractor by decreasing profit or charging a fee for failing to achieve targets.

Although CBOC contracts included a performance work statement that explained VHA's requirements in terms of required results and performance metrics and instructions for measuring them, the contracts did not include performance incentives. In addition, the contract files for CBOC contracts did not explain why VHA determined that performance incentives were not appropriate for CBOC contracts. All but one of the contracting officials the audit team interviewed expressed interest in adding performance incentives to the CBOC contracts to help motivate contractors to perform better. Yet, the contracting officers said they were restricted by the CBOC contract requirements template. Therefore, the program offices should determine and document whether positive and negative performance incentives should be used for CBOC contracts in accordance with guidance in the FAR.

Performance Incentives in the Commercial Market

Performance incentives are widely used in commercial industries for contracts similar to CBOC contracts. CBOC contracts are awarded as a commercial service, which are defined as a service that is offered and sold competitively in the commercial market and is performed under standard commercial terms and conditions.⁵² To identify standard commercial terms and conditions, the FAR requires agencies to conduct research before developing new contract requirements, which could include identifying commercial practices and contract types.⁵³ VA acquisition guidance says market research is a collaborative effort that is primarily led by the program office or the organization requiring the contract with support from the contracting office.⁵⁴

CBOC contracts use a similar payment method as contracts in the commercial market and pay contractors a fixed price per patient assigned at the clinic per month. According to the American

⁵⁰ FAR 16.202. Updated in RFO FAR 16.202-1.

⁵¹ Office of Federal Procurement Policy, *Appropriate Use of Incentive Contracts*, December 4, 2007.

⁵² 38 U.S.C. § 8153.

⁵³ FAR 10. Updated in RFO FAR 10 and the supplemental FAR Companion, Version, 2.0, October 30, 2025.

⁵⁴ VA Acquisition Manual Part M810, "Market Research."

College of Physicians, many payment plans of that type include a performance incentive that is paid to a physician based on how well the health plan does financially.⁵⁵

MSO officials explained that VHA’s payment structure was established based on policies from CMS. CMS has two payment models that use a similar payment structure to pay for primary care medical services, and both include performance incentives.⁵⁶ For example, one of CMS’s models includes a positive incentive that pays a financial incentive of up to a 50 percent increase in the contract price if a practitioner exceeds performance standards or a negative incentive that withholds 10 percent of the contract price if the practitioner does not meet standards.⁵⁷ CMS officials told the OIG team that they use performance incentives in the payment models because money motivates medical practices to perform better.

While VHA contracting officers conducted market research to identify potential companies that could bid on CBOC contracts, they said they did not research commercial practices or contract types. Instead, the contracting officers asserted that they were required to use the CBOC contract requirements template, which defined the contract requirements and contract types—and they said they assumed MSO conducted research on commercial practices and contract types before publishing the contract requirements template. However, MSO and Office of Primary Care officials said they did not conduct market research before publishing updated templates. Even though contracting officers are required to use the contract requirements template and cannot change the contract type or payment method, program office officials said market research was the responsibility of contracting officers.⁵⁸ Therefore, MSO and the Office of Primary Care should develop and implement procedures to identify, evaluate, and incorporate commercial practices where appropriate—including performance incentives—and contract types into subsequent updates to the CBOC contract requirements template.

Performance Incentives Removed

Before 2017, the CBOC contract requirements template did include negative performance incentives. The CBOC contract requirements template published in July 2016 called for reducing a contractor’s monthly or quarterly payment by a fixed percentage when the contractor did not meet certain performance metrics.⁵⁹ Specifically, six of the 16 performance metrics in the 2016 template included a negative performance incentive so that VHA could have withheld up to

⁵⁵ “Understanding Capitation” (web page), American College of Physicians, accessed October 3, 2023, <https://www.acponline.org>.

⁵⁶ 42 C.F.R. § 422.208 (2021) authorizes CMS to use capitation plans that include a performance incentive, referred to as a “withhold.”

⁵⁷ “Primary Care First Model Options” (web page), Centers for Medicare & Medicaid Services, accessed November 30, 2023, <https://www.cms.gov>.

⁵⁸ The VA Acquisition Manual Part M810 states that market research is a collaborative effort that is primarily led by the program office with support from the contracting office.

⁵⁹ Officials stated that negative performance incentives were also in templates before the 2016 version.

70 percent of a contractor’s payment when the contractor did not meet them.⁶⁰ According to staff in VA’s Office of General Counsel, negative performance incentives must be based on a reasonable and documented forecast of anticipated damages. Therefore, withholding up to 70 percent of a contractor’s monthly payment for missing performance metrics would appear excessive and could potentially be unenforceable considering that the contractor would have incurred operating costs to provide medical care for patients. Table 3 lists the six performance metrics and associated negative incentives from the 2016 CBOC contract requirements template.

Table 3. Performance Incentives in the 2016 Contract Template

Performance metric	Requirement	Positive incentive	Negative incentive
Clinical reminders	Complete 90% of clinical reminders each month	Satisfactory or better past performance rating	85% to 89.9%: 5% reduction in monthly invoice
			84.9% or lower: 10% reduction in monthly invoice
New patient wait time	Complete 99.7% of new-patient appointments within 30 days	Satisfactory or better past performance rating	95% to 99.6%: 10% reduction in monthly invoice
			89% to 94.9%: 15% reduction in monthly invoice
Clinical encounters	Complete 99.9% of documentation for clinical encounters each month	Satisfactory or better past performance rating	90% to 99.9%: 5% reduction in monthly invoice
			89.9% or lower: 10% reduction in monthly invoice
Pharmacy	90% approval of pharmacy drug requests	Satisfactory or better past performance rating	89.9% or lower: 10% reduction in quarterly invoice
Pharmacy new drug order requests	95% of new drug requests follow VA prescribing guidelines	Satisfactory or better past performance rating	94.9% or lower: 10% reduction in quarterly invoice
Appointment cancellations	See 100% of patients within 2 weeks of cancelled appointment	Satisfactory or better past performance rating	95% to 99.9%: 10% reduction in monthly invoice
			90% to 94.9%: 15% reduction in monthly invoice

Source: July 2016 VHA contract requirements template for CBOC contracts.

In February 2017, an attorney for VA’s Office of General Counsel concluded that although negative performance incentives are permissible in federal government contracts, they are

⁶⁰ The 2016 contract template also discussed positive performance incentives, but the incentives were not monetary incentives, as required by the FAR.

complex, require significant documentation, and are generally not recommended by counsel.⁶¹ In November 2016 and March 2017, MSO staff published a newsletter and a news bulletin to staff saying they were removing all language about performance incentives from the CBOC contract requirements template based on this guidance from VA’s Office of General Counsel. VHA Office of Acquisitions officials told the OIG team that VHA had not awarded any contracts, including CBOC contracts, that included performance incentives since they received this guidance from the Office of General Counsel.

Office of General Counsel officials clarified the intent of the February 2017 guidance in an October 2024 interview with the audit team, saying it was not meant to discourage contracting offices from using performance incentives. Instead, they said the guidance was written to ensure contracting officers documented their calculations in the contract file and ensured those calculations were based on a reasonable, documented forecast of anticipated damages. Furthermore, the General Counsel officials said contracting officers could not support their rationale for the amount withheld for negative performance incentives when contractors challenged the reduced payments in court, so the guidance was intended to encourage contracting officers to coordinate with their assigned legal counsel when considering the use of performance incentives.

To increase consistency with the FAR and the commercial market, VHA should reconsider incorporating performance incentives in CBOC contracts “to the maximum extent practicable.” When evaluating how to implement performance incentives, VHA should coordinate with VA’s Office of General Counsel to ensure the incentives are reasonable and defensible.

Contract Requirements Not Met

In part because the contract template included limited capabilities to motivate or hold contractors accountable, contracting officers and VA medical centers accepted performance that did not meet contract requirements. The FAR says contracting officers are responsible for accepting contracted services and that acceptance indicates the services conform with applicable contract quality and quantity requirements.⁶² It also says the government pays the contractor for services that it accepts.⁶³ The contracting officer therefore must reject services that do not comply with contract requirements when the noncompliance is critical or major or when the services are

⁶¹ VA Office of General Counsel guidance, Service Area Office Central, Volume 6, Issue 2, “Legal Corner Making Sense of Liquidated Damages and Disincentives,” February 2017. The main focus of the published guidance was not performance incentives, and it did not discuss the use of positive performance incentives. Rather, the guidance discussed the misuse of liquidated damages by contracting officers. Liquidated damages are used to compensate the government for probable damages when timely performance is so important that the government may reasonably expect to suffer damage if performance is delinquent and the amount of damage would be difficult or impossible to estimate accurately.

⁶² FAR 46.5. Updated in RFO FAR 46.5.

⁶³ FAR 52.232-1.

otherwise incomplete. It is critical for contracting officers to discourage repeated noncompliance with contract requirements by taking actions such as rejecting services that do not comply with the contract.⁶⁴

As discussed in finding 1, the contractors for the 11 contracts the OIG sampled for 19 CBOCs consistently did not meet contract performance metrics. Specifically, from January 2022 through March 2024, the contractors did not meet 56 percent of the performance metrics on average (table 4).

Table 4. Performance Ratings for the Sampled CBOCs

Location	Percentage not met	Percentage met	Percentage not rated
Stuart, Florida	71%	25%	5%
Victorville, California	67%	27%	6%
Murrieta, California	66%	30%	4%
Corona, California	65%	32%	3%
Palm Desert, California	64%	26%	11%
Fort Pierce, Florida	64%	31%	5%
Vero Beach, Florida	58%	35%	6%
Danville, Virginia	57%	27%	17%
Plattsburgh, New York	56%	42%	2%
Rancho Cucamonga, California	56%	41%	3%
Boca Raton, Florida	54%	42%	5%
Jefferson County, New York	47%	26%	26%
Tompkins County, New York	47%	25%	28%
Okeechobee, Florida	45%	50%	5%
McComb, Mississippi	42%	42%	16%
Oswego, New York	32%	39%	29%
Bogalusa, Louisiana	Not Rated*		
Braunfels, Texas	Not Rated*		
Copperas Cove, Texas	Not Rated*		
Average	56%	34%	11%

Source: VA OIG analysis of COR oversight reports for sampled contracts.

Note: Percentages for some locations do not sum precisely due to rounding.

* The CORs for three CBOC contracts did not conduct or document performance reviews based on the contractual performance metrics.

⁶⁴ FAR 46.407. Updated in RFO FAR 46.407.

Although the CORs reported that the contractors did not meet most performance metrics and did not comply with contract requirements, contracting officers and CORs almost always accepted the services provided at the CBOCs.⁶⁵ By accepting services despite performance issues, the contracting officers and VA medical centers may not have discouraged the repeated noncompliance.

Finding 2 Conclusion

Contracts for CBOCs are meant to provide high-quality, safe, timely, and cost-effective care to veterans; however, the unique nature and the limited number of contractors that perform the work create challenges for VHA to motivate contractors and hold them accountable for meeting the requirements of the contracts. Without effective motivational tools, such as performance incentives, rooted in the Federal Acquisition Regulation, the CBOC contractors consistently did not meet the requirements of their contracts. Therefore, VHA should implement ways to motivate the contractors that provide services at CBOCs to ensure veterans receive consistent, high-quality, and timely care.

Recommendations 10–12

The OIG made the following recommendations to the under secretary for health and the VHA chief operating officer:

10. Review and evaluate how contracting offices rated community-based outpatient clinic contractors in the Contractor Performance Appraisal Reporting System and, if necessary, develop and disseminate additional guidance or training to contracting offices to help them appropriately rate community-based outpatient clinic contractors in accordance with the performance metrics and the broad categories in the Contractor Performance Appraisal Reporting System.
11. Determine whether positive and negative performance incentives should be used for community-based outpatient clinic contracts to motivate contractors to provide high-quality health care, in accordance with Revolutionary FAR Overhaul Federal Acquisition Regulation provisions 16.202 and 16.403-2.
 - a. If performance incentives are appropriate for community-based outpatient clinic contracts, ensure the Medical Sharing/Affiliate Office works with the Office of General Counsel to develop and implement measurable, reasonable, and defensible positive and negative performance incentives.

⁶⁵ Only one COR for the sampled contracts said she withheld payment of an invoice because of noncompliance with a contractual performance metric.

- b. If performance incentives are not appropriate for community-based outpatient clinic contracts, ensure the Medical Sharing/Affiliate Office and each network contracting office documents in its contract files the reasons performance incentives are not used to the maximum extent practicable, in accordance with Revolutionary FAR Overhaul Federal Acquisition Regulation provision 16.402-2.
12. Develop and implement procedures to identify, evaluate, and incorporate commercial practices and contract types into the community-based outpatient clinic contract requirements template before publishing updated versions, in accordance with 38 U.S.C. § 8153 and Revolutionary FAR Overhaul Federal Acquisition Regulation part 10; the procedures should evaluate whether the contract payment structure for community-based outpatient clinic contracts is consistent with current commercial practices.

VA Management Comments

On November 3, 2025, the former acting under secretary for health concurred with recommendations 10 and 11 and concurred in principle with recommendation 12. On February 10, 2026, the current under secretary for health advised that he is forming a work group to assess and standardize the process for CBOC contract oversight based on this OIG report. He said the results of the work group may change the action plans previously provided by the former acting under secretary.

VHA's proposed actions to address each recommendation are summarized below, and the full text of the former acting under secretary's response is in appendix B.

- **Recommendation 10.** The former acting under secretary for health said VHA's Office of Acquisitions plans to review the CPARS ratings for CBOC contracts and determine whether additional guidance or training is needed.
- **Recommendation 11.** The former acting under secretary for health said VHA's Office of Acquisitions plans to coordinate with the Office of General Counsel to assess whether performance incentives should be used for CBOC contracts.
- **Recommendation 12.** The former acting under secretary for health said procedures are in place to update the CBOC template and that, as mentioned in response to earlier recommendations, the Chief Office of Operations will create a work group to review existing procedures for updating the CBOC template in coordination with the appropriate program offices, with the goal of ensuring that future published updates align with commercial practices, contract types, and commercial contract payment structures.

OIG Response

The comments and corrective actions from the former acting under secretary for health were responsive and meet the intent of recommendations 10 and 11. The comments and corrective actions for recommendation 12 were only partially responsive. As discussed, officials from MSO, the Office of Primary Care, and VHA contracting offices said they did not conduct market research in accordance with FAR part 10 before publishing updated CBOC contract requirements or awarding new CBOC contracts. Establishing a work group to review the existing procedures for updating the CBOC template is not a long-term solution. VHA should develop and implement procedures—which could include assigning responsibilities—to identify, evaluate, and incorporate commercial practices and contract types into the CBOC contract requirements template before publishing updates.

The OIG will monitor the implementation of the planned actions and will close the recommendations when the under secretary provides evidence demonstrating sufficient progress in addressing the issues identified.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from April 2024 through July 2025 and reviewed procedures for overseeing contracted community-based outpatient clinics (CBOCs) at the Veterans Health Administration (VHA), which included oversight by VHA’s program offices, contracting offices, and contracting officer’s representatives (CORs). The audit team focused on whether VHA officials complied with federal regulations and VA acquisition, program management, and governance policies and reviewed and analyzed contract requirements templates published from 2016 through 2024. The team obtained and analyzed contract documentation, including performance reviews conducted by CORs from fiscal year 2022 through fiscal year 2024.

Sampling Methodology

As of December 2023, VHA had 92 contracts for 107 CBOC locations, initially valued at about \$2 billion with an objective to serve an estimated 283,732 patients. The team created a sample frame of the contracts that had an effective date of January 2023 or earlier and expired no earlier than July 2024. Therefore, the universe included 56 contracts for 67 CBOC facilities. To ensure sufficient performance data for comparison, the team excluded contracts that had less than a year of performance as of January 2024. The team also excluded contracts that expired before July 20, 2024, to minimize reporting on contracts that were no longer active.

The audit team statistically selected a sample of 11 contracts for 19 CBOCs from the population of contracts. The population was stratified by regional procurement office and categorized in three strata as seen in table A.1. The sample includes three certainty-sampled contracts and eight randomly selected contracts, where randomly sampled contracts were selected with a probability proportional to the estimated number of veterans served in the base year of the contract.

Table A.1. Stratified Population

Regional procurement office	Population size	Sample size
Central	16	2
East	23	6
West	17	3

Source: VA OIG statistician’s stratified population based on data obtained from a list from the Medical Sharing/Affiliate Office (MSO) of CBOC contracts as of December 1, 2023, and verified using VA’s electronic contract management system.

Audit Methodology

The audit team examined relevant sections of the Federal Acquisition Regulation, including the Revolutionary FAR Overhaul initiative, and VA and VHA policies, procedures, and directives. The significant VA and VHA criteria reviewed included the following:

- VA Notice 24-08, Establishment of the Veterans Affairs Acquisition Lifecycle Framework, March 8, 2024
- VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Title 38 U.S.C. § 8153*, May 10, 2018
- VHA Directive 1217, *VHA Central Office Operating Units*, September 10, 2021, and VHA Directive 1217(1), *VHA Operating Units*, August 14, 2024
- VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017 (amended October 4, 2019)
- VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office*, February 21, 2023
- VHA Procurement Manual, part 873, “Health-Care Resource Specialized Procurements and Sharing Agreements under Title 38 U.S.C. § 8153 SOP [Standard Operating Procedure]”

The audit team presented its findings to VHA officials in November 2024, July 2025, and September 2025. The audit team interviewed officials from VA’s Office of General Counsel, the VHA Office of Acquisitions, the Medical Sharing/Affiliate Office (MSO), the Office of Primary Care, and the Centers for Medicare & Medicaid Services; contracting officers and CORs for the 11 sampled contracts; and three CBOC contractors. The audit team obtained and analyzed contract files from VA’s electronic contract management system and contracting officials—including contracts, modifications, quality assurance surveillance plans, COR performance reviews, COR qualifications and delegations, and Contractor Performance Assessment Reporting System ratings. The team also obtained and analyzed data from MSO’s SharePoint site, VA Pyramid Analytics, VA Patient Aligned Care Team Compass, and VHA’s performance measure reports.

Internal Controls

The team assessed internal controls to determine whether they were significant to the audit objective. This included consideration of the five internal control components: control environment, risk assessment, control activities, information and communication, and

monitoring.⁶⁶ In addition, the team reviewed the principles of internal controls as associated with the objective and identified two components and two principles as significant.⁶⁷ The team identified internal control deficiencies during this audit and proposed recommendations to address those listed in table A.2.

Table A.2. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this report
Control environment	2. The oversight body should oversee the entity's internal control system.	Although MSO is the national program office responsible for administrative oversight of CBOCs, its oversight ends once a contract is awarded.
Control activities	10. Management should design control activities to achieve objectives and respond to risks.	MSO did not have adequate controls designed to hold contractors accountable for poor performance.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the Government Accountability Office's Standards for Internal Control in the Federal Government.

Data Reliability

The VA Office of Inspector General (OIG) relied on contract file information obtained from the electronic contract management system and MSO's SharePoint site. To verify the reliability of data for the contract universe, the OIG compared the list of CBOC contracts obtained from MSO's SharePoint site to signed contracts obtained from the electronic contract management system. The team verified the contracts' total dollar values, estimated number of patients, locations, and contractors. The OIG also relied on performance review data obtained from contracting officers or the electronic contract management system, VA Pyramid Analytics, VA Patient Aligned Care Team Compass, and VHA's performance measure reports. The audit team conducted limited data reliability on the data by comparing data collected from multiple sources to ensure sufficient reliability. The OIG concluded that the data were reliable and appropriate to support the findings and recommendations.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions

⁶⁶ Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-25-107721, May 2025.

⁶⁷ Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that could have existed at the time of this audit.

based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: VA Management Comments

Department of Veterans Affairs Memorandum

Date: November 3, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Audit of National Community-Based Outpatient Clinic (CBOC) Contracts (VIEWS 13662399).

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's draft report on Audit of National Community-Based Outpatient Clinic (CBOC) Contracts. Attached is the Veterans Health Administration's (VHA) action plan.
2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD, MBA, FACHE

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Office of Inspector General (OIG) Report – Management of Community-Based Outpatient Clinics Needs Improvement to Ensure Contractors Provide Required Services (Project Number 2024-00900-AE-0035)

Recommendation 1: Review and update VHA Directive 1660.07, “Medical Sharing/Affiliate National Program Office,” to delegate all required program office responsibilities for the community-based outpatient clinic contracts throughout the program’s life cycle to an appropriate headquarters-level office or collaboration of offices, as defined in VHA Directive 1217, “VHA Operating Units” and VA’s Acquisition Lifecycle Framework.

VHA Comments: Concur in Principle. VHA Chief Office of Operations (COO) concurs that VHA Directive 1660.07 should be updated to reflect pending changes to VHA organizational structure and to clarify the responsibilities of the Medical Sharing/Affiliate National Program Office (MSO) within the new structure. VHA Directive 1229 (1) assigns quality, evaluation, and performance management of contracted CBOCs to the VHA COO, VISN Directors and the CBOC administrative parent facilities. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, Veterans Integrated Service Network (VISN) Leadership, and designated contracting officer representatives, to review VHA Directive 1229 (1) to ensure it assigns all responsibilities required by VHA Directive 1217 to the appropriate office(s) to address the OIG’s recommendation.

Status: In Progress

Target Completion Date: April 2026

Recommendation 2: Develop and implement procedures for a headquarters-level office to monitor overall compliance with contract requirements and use the results to reassess program policies or contract requirements.

VHA Comments: Concur in Principle. Procedures for monitoring overall compliance with contract requirements already exist in the performance work statement (PWS) template, specifically in the Quality Assurance Surveillance Plan (QASP). Per VHA Directive 1229(1), one headquarters office does not monitor the overall compliance of all CBOC contracts. Performance management including overall compliance is the responsibility of the VHA COO, VISN Directors and the CBOC administrative parent facilities. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to assess the program policies and contract requirements to assess overall CBOCs. Please note the CBOC standards apply to both VA operated, and contractor operated.

Status: In Progress

Target Completion Date: August 2026

Recommendation 3: Develop a formal feedback process, such as a program life cycle review process, for contracting officers and contracting officer representatives, medical facilities, and contractors who work on community-based outpatient clinic contracts to provide lessons learned, issues encountered, and other feedback about establishing new clinics and the performance at the clinics.

VHA Comments: Concur in Principle. A current feedback process does exist, and responsibilities are outlined in VHA Directive 1229 (1). The COO will charter a workgroup consisting of the Office of

Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to review current feedback processes and make recommendations for process updates.

Status: In Progress **Target Completion Date: August 2026**

Recommendation 4: Conduct an assessment of contractor compliance with all active community-based outpatient clinic contracts, then evaluate whether the community-based outpatient clinic contract performance metrics are measurable, reasonable, and attainable.

VHA Comments: Concur in Principle. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to assess existing contractor performance results to ensure the metrics are measurable, reasonable, and attainable to address the OIG's recommendation. The workgroup will not perform new assessments of contracted CBOCs.

Status: In Progress **Target Completion Date: August 2026**

Recommendation 5: Coordinate with the Office of General Counsel to determine whether creating a separate contract line item from the operational costs for contracted community-based outpatient clinics to pay start-up costs, including construction costs, would assist in the administration of these contracts and increase competition among contractors; then update the community-based outpatient clinic performance work statement template to reflect any change made as a result of this consideration.

VHA Comments: Concur. VHA Office of Acquisitions concurs with this recommendation. MSO will re-engage the Office of General Counsel (OGC) regarding a separate contract line item for build out/start-up costs. When MSO previously collaborated with the OGC regarding how to address build out/start-up in Community Based Outpatient Clinic (CBOC) procurements, OGC did not recommend including a separate contract line item for start-up. The guidance from OGC was that Contracting Officers must include an addendum to FAR provision 52.212-1 to advise offerors that they may submit alternative pricing or payment methods in their pricing proposal which address construction costs incurred during the build-out phase. MSO issued News Bulletin Number 50 dated April 7, 2023, communicating this requirement to the field. MSO will follow up with OGC to determine whether that office currently recommends updates to the CBOC PWS.

Status: In Progress **Target Completion Date: April 2026**

Recommendation 6: Assess how medical centers create and maintain the billable roster for community-based outpatient clinic contracts; based on the results, develop and implement efficient, accurate, and consistent procedures for developing and maintaining the billable rosters.

VHA Comments: Concur. Facilities develop billable rosters in accordance with language provided in the contracted CBOCs PWS template using the procedures that best meet their needs. Procedures for developing billable rosters are determined by the facility based on their specific operational needs, requirements, and resources. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to address this OIG recommendation. This group will assess the current state of billable roster creation and maintenance and based on the results, make recommendations to improve the accuracy and efficiency of the process.

Status: In Progress **Target Completion Date: August 2026**

Recommendation 7: Coordinate with the VA medical centers that have VA-contracted community-based outpatient clinics to conduct a risk assessment to evaluate the responsibilities, time requirements, and qualifications of community-based outpatient clinic contracting officer representatives; then publish clear guidance or recommendations for facilities to make sure they have appropriately experienced, trained, and certified staff to oversee the performance of community-based outpatient clinic contracts.

VHA Comments: Concur in Principle. Guidance currently exists regarding COR requirements. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to address the OIG's recommendation. The workgroup will notify Acquisitions if the current Contracting Officer Representative (COR) guidance should be revised after the completion of the risk assessment.

Status: In Progress

Target Completion Date: August 2026

Recommendation 8: Assess the certification levels of the CORs assigned to all CBOC contracts and make recommendations to the medical centers for assigning appropriately experienced CORs or to provide any additional training or assistance to existing CORs, if necessary.

VHA Comments: Concur in principle. VHA Office of Acquisitions will assess the FAC-COR certification levels of CORs assigned to all current CBOC contracts. Any results from this assessment will be shared with the medical centers, as necessary. The Medical Centers will determine if a new COR should be assigned or if an existing COR requires additional training.

Status: In Progress

Target Completion Date: April 2026

Recommendation 9: Develop and implement procedures to require VA medical centers and contracting offices to verify that the Office of Information Technology can meet start-up requirements for new community-based outpatient clinic locations as part of the contract review process.

VHA Comments: Concur in Principle. The current contract review process includes procedures requiring VA medical centers and contracting offices to verify that the Office of Information and Technology (OIT) can meet start-up requirements for new community-based outpatient clinic locations. Complex procurements such as contracted CBOCs require a facility planning team appointed by the designated facility Executive Leadership Team (ELT) member. This team consists of stakeholders from the various facility offices providing clinical and non-clinical services in the contracted CBOC, such as primary care, mental health, pharmacy, laboratory, and OIT. As part of the planning team, OIT staff assist in identifying OIT requirements for the contracted CBOC and ensuring OIT start-up requirements can be met, preventing the burden of CBOCs having to create their own solutions to OIT deficiencies. Active OIT participation in the planning team can prevent delays and deficiencies in services for contracted CBOCs. The facility planning team, overseen by the designated facility ELT members, ensures that all start-up requirements can be met as part of the contract review process. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to address the OIG's recommendation. The group will evaluate the state of involvement of OIT in contracted clinic planning teams and develop recommendations to support involvement of OIT on these teams to ensure OIT can meet start up requirements for clinics.

Status: In Progress

Target Completion Date: August 2026

Recommendation 10: Review and evaluate how contracting offices rated community-based outpatient clinic contractors in the Contractor Performance Appraisal Reporting System, and if necessary, develop and disseminate additional guidance or training to contracting offices to help them appropriately rate community-based outpatient clinic contractors in accordance with the performance metrics and the broad categories in the Contractor Performance Appraisal Reporting System.

VHA Comments: Concur. VHA Office of Acquisitions will review the Contractor Performance Assessment Reporting System (CPARS) ratings for CBOC contracts and determine whether additional guidance or training is needed.

Status: In Progress

Target Completion Date: April 2026

Recommendation 11: Determine whether positive and negative performance incentives should be used for community-based outpatient clinic contracts to motivate the contractors to provide high-quality health care, in accordance with FAR 37.6, FAR 16.202, and FAR 16.402-2.

a. If performance incentives are appropriate for community-based outpatient clinic contracts, ensure the Medical Sharing/Affiliate Office coordinates with the Office of General Counsel to develop and implement measurable, reasonable, and defensible positive and negative performance incentives.

b. If performance incentives are not appropriate for community-based outpatient clinic contracts, ensure the Medical Sharing/Affiliate Office and each network contracting office documents in the contract files the reasons why performance incentives are not used to the maximum extent practicable, in accordance with FAR 16.402-2 and FAR 37.6.

VHA Comments: Concur. VHA Office of Acquisitions will coordinate with the Office of General Counsel to assess whether performance incentives should be used for CBOC contracts.

Status: In Progress

Target Completion Date: April 2026

Recommendation 12: Develop and implement procedures to identify, evaluate, and incorporate commercial practices and contract types into the community-based outpatient clinic contract requirements templates before publishing updated versions, in accordance with 38 U.S.C. § 8153 and FAR part 10; the procedures should evaluate whether the contract payment structure for community-based outpatient clinic contracts is consistent with current commercial practices.

VHA Comments: Concur in Principle. Existing procedures are in place for making updates to the CBOC templates. The COO will charter a workgroup consisting of the Office of Acquisitions contracting subject matter experts, additional relevant National Program Offices, VISN Leadership, and designated contracting officer representatives, to review existing procedures for making updates to the CBOC templates in coordination with the appropriate program offices to ensure that future published updates continue to align with commercial practices, contract types, and commercial contract payment structure.

Status: In Progress

Target Completion Date: April 2026

OIG Contact and Staff Acknowledgments

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