STATEMENT OF
JON A. WOODITCH
DEPUTY INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
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FOR THE
OFFICE OF INSPECTOR GENERAL

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INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to address the FY 2009 budget for the Office of Inspector General (OIG). Almost a year ago on February 15, 2007, we testified before this committee and discussed some of the challenges the OIG faces in providing useful and helpful oversight of the Department of Veterans Affairs (VA) to ensure it effectively and economically performs its mission of serving our Nation's veterans. Since then, I am proud to say that much has been accomplished, but as we said last year there is still much to be done.

Today, I will highlight some of our accomplishments over the past year, present a number of key issues facing VA, and discuss how we would invest budget resources made available to the OIG in addressing some of these issues. With me today are the Assistant Inspectors General for Audit, Healthcare Inspections, and Investigations who will answer questions about their specific programs.

RETURN ON INVESTMENT

The OIG seeks to help VA become the best-managed service delivery organization in Government. OIG audits, health care inspections, investigations, and Combined Assessment Program (CAP) reviews recommend improvements in VA programs and operations, and act to deter waste, fraud, abuse, and mismanagement. For 2007, OIG funding supported 443 FTE from appropriations. An additional 25 FTE was funded under a reimbursable agreement with VA to perform pre-award and post-award contract reviews. During 2007, the OIG exceeded its overall performance goals. For example, monetary benefits for the year were $820 million, for a return on investment of $12 for every dollar expended. Collectively, the OIG issued a total of 217 audit, health care inspection, and contract review reports, with over 500 recommendations for corrective action. We also completed 1,181 criminal investigations, which led to 2,061 arrests, indictments, convictions, and administrative sanctions. We also responded to over 19,000 contacts received by the OIG Hotline.

Examples of some of the more notable accomplishments during 2007 and the first part of this year by our Office of Healthcare Inspections included a national report on the Veterans Health Administration's (VHA) mental health strategies for suicide prevention, the development of a significant national database to aid in the quantitative assessment of care for Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans transitioning from DoD to VA, and numerous veteran or facility-specific issue reports, such as one involving quality of surgical care at the Marion, Illinois, VA Medical Center.

In the area of information security, an OIG administrative investigation found that a breakdown in management controls and accountability contributed to the disappearance of a VA-owned external hard drive believed to contain personally identifiable information for over 250,000 veterans and 1.3 million medical providers. Our audit on outpatient waiting times identified data integrity problems impacting the reliability of reported waiting times by VA.

OIG criminal investigators arrested 133 fugitive felons, helped gain the conviction of a VA pharmacy manager for taking over $100,000 in kickbacks from a vendor, and uncovered a VA nurse who had stolen controlled and non-controlled substances from a VA medical center for 9 years and conspired with relatives to distribute the drugs.

We appeared before this Subcommittee several times during the past year where we testified on the following issues.

- Long-standing risks and vulnerabilities associated with protecting and safeguarding VA information and information technology systems.
- Quality management and other facility-specific issues at the Salisbury, North Carolina, VA Medical Center.
- Inappropriate contract modifications at the VA Boston Healthcare System that were paid with expired funds in violation of Federal appropriation laws.
- Continuing concerns with variances in Veterans Benefits Administration disability compensation payments by state.
- Inaccurate reporting by VHA on outpatient waiting times.
- VA credentialing and privileging and its impact on patient safety.

RESOURCE LEVELS 2008 AND 2009

While we have accomplished much, more remains to be done. For 2008, OIG funding is $80.5 million, which includes $7.9 million in emergency funding authorized by the President. This funding supports 488 FTE. We are very appreciative of this funding and we already have launched an aggressive recruiting effort to fill these positions. For 2009, the budget submitted for the OIG is $76.5 million, which supports 440 FTE.

The OIG provides independent and objective oversight that addresses mission-critical activities and programs in health care delivery, benefits processing, financial management, procurement practices, and information management. We plan our work in each of these strategic areas, which are aligned with VA's strategic goals. The OIG Major Management Challenges for VA that are presented in the VA annual Performance and Accountability Report are also reported by

these strategic areas. I would now like to highlight some of the key issues that we will focus on this year and in 2009 by strategic goal.

Health Care Delivery

Most critical among the many challenges VA faces is transition and quality of health care for veterans. Due to concerns that the controls currently in place in VHA are not functioning correctly to ensure that veterans receive quality health care, we will review compliance with VA's new peer review policy. CAP reviews will be expanded to review credentialing and privileging actions taken at local facilities. In addition, we will compare the complexity of clinical activities performed at a facility with the facility's clinical capabilities to ensure proper consideration is given during the privileging process so that veterans are not exposed to excessive risk of poor clinical outcomes based upon the location where care is provided.

Veterans who have returned from current conflicts experience two medical traumas with great frequency: Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). These conditions have an impact that is variably expressed by returning war veterans. We will use data sets like the OIF/OEF database developed by the OIG to understand the clinical care provided to this population and the extent of their unmet clinical needs. OIG has reported on the mental health issues of this population through individual care reports and through programmatic reviews. Both of these formats will be utilized to evaluate and provide data to improve our Nation's response to those afflicted with TBI and PTSD.

We will initiate reviews of the care provided by the more than 800 community based outpatient clinics (CBOCs) and 200 Vet Centers. For many veterans, especially those in rural areas, CBOCs are their most available point of access to medical care. This population is called upon to either travel some distance for care or be reliant upon the fee basis system. It is only through a review of the medical needs of the CBOC and Vet Center populations that relevant access to care issues can be reviewed. The number of systematic onsite reviews will be based on available funding and competing priority work. At CBOCs, the mental health care provided will be reviewed as a subset of the medical care that is provided. At Vet Centers, we will evaluate those activities that are considered within the provision of health care to ensure that veterans receive the same standard of care that they should receive at a primary medical clinic.

As anesthesia capabilities, imaging, and noninvasive surgical techniques have improved, there is a risk that the disparity between the specialty medical care available at a large VA medical center (VAMC) compared to that available at a smaller more rural VAMC will place veterans at increased risk if they are unwilling or unable to travel to a more sophisticated VAMC, or if they are not provided fee basis care when the required care is available privately in their local area. We will devote attention to this issue through a focused nationwide review.

VHA research poses inherent challenges. Beyond the obvious fiscal accountability issues, VA research must have oversight that keeps it from harming patients or getting in the way of needed treatment. We will continue to consider research a high priority issue for oversight.

We will undertake a national review into aspects of the home based medical care that is provided to elderly veterans to ensure that these programs meet the needs of veterans. CAP reviews will

maintain a focus on the long-term care issues that each facility must address and will highlight discrepancies with national policy and best practices.

We will continue to review programs designed to assist those veterans who are at great risk because of their homelessness or other lifestyle characteristics by building on our reports in the past on homeless veteran care programs, aid and assistance programs, and similar efforts through a national project designed to highlight the impact of these programs.

Budgeting, planning, and resource allocation in VA are extremely complex, but critical components to serving veterans' health care needs. The effectiveness of these activities is compounded by continuing uncertainty, from year to year, of the number of patients who will seek care from VA. We will assess the Veterans Equitable Resource Allocation system which tracks demand and usage across VA, to ensure equitable distribution of resources as veteran demographics and demand change over time. Further, accurate information on the demand for care is critical to effectively manage VA's fee-basis program for providing health care outside of VA facilities.

The Veterans Integrated Service Networks (VISNs) oversee and manage medical facilities across the Nation but their effectiveness is questionable when we and the Government Accountability Office continue to identify issues in the management and administration of VA medical facilities. We will assess the need for VISNs to adopt a standard approach for overseeing and administering the direct management and support functions within the VISN, such as the Medical Care Collection Fund, equipment accountability, and contracting.

VHA spends a significant amount of its budget on pharmaceuticals and these substances are subject to loss and theft without strong controls and continued OIG oversight. In addition to assessing these controls it is important to detect drug diversion because of the possible impact of impaired health care professionals on the quality of care provided veterans; patients receiving diluted medication and being unable to properly control pain; and physicians who mistakenly believe a patient is getting a particular dosage of medication because the chart contains erroneous information intentionally entered by the diverter. With the increasing number of automated tools available to detect drug diversion by VA health care professionals, we will exploit this technology to proactively detect possible drug diversion instead of waiting for allegations to be received. We will also continue to work closely with local law enforcement to combat the sale and distribution of contraband drugs on or adjacent to VAMC property which undermines the rehabilitation of patients with substance abuse problems.

Benefits Processing

Large inventories of pending claims for compensation and pension benefits have been a problem for many years. Making headway has proven difficult because VA faces an increasing disability claims workload from returning OIF/OEF veterans, reopened claims from veterans with chronic progressive conditions, and additional claims from an aging veteran population. Controls over processing benefit claims and actions are not always effective, leading to delays, errors, and increased potential for improper payments. The complexity of benefits laws, court decisions interpreting those laws, technology issues, workload, and staffing issues contribute to VA's benefit processing problems. VA has been authorized to hire additional claims examiners that

may help to reduce the backlog, but it will be challenged to recruit, train, and incorporate these raters effectively into a productive workforce. Because these factors will continue to present VA with major challenges, we will assess the timeliness and accuracy of processing disability claims for monetary benefits. In addition to monetary benefit programs, VA also provides rehabilitation, educational, and independent living benefits to veterans. We believe these programs will benefit from increased oversight, scrutiny, and revision to effectively serve the needs of our veterans.

Financial Management

VA's most costly procurement failures involved the development and implementation of information technology (IT) systems intended to provide better visibility and oversight of VA programs and operations, including its financial services. As such, VA lacks an integrated financial management system to safeguard and account for financial operations. We plan to review VA's efforts to replace existing legacy systems, which do not adequately support preparation of VA's consolidated financial statement (CFS). While our most recent CFS audit reported that key internal controls and reconciliation processes are not performed consistently and completely, it did not tell us how this condition affects the Medical Care Collection Fund receivables worth approximately $1 billion. Other key financial activities, such as budget formulation and execution, the accuracy and reliability of VA financial, statistical, budget, and performance measures and reports, programmatic controls over financial operations, grants management, and debt collection activities also remain a daily challenge for VA managers and impact the integrity of information at the facility and program level. We will prioritize and review these as funds are available.

Procurement Practices

OIG has three critical roles in evaluating VA's procurement programs and operations: oversight of procurement practices at VA Central Office and the field to ensure compliance with applicable laws and regulations; investigations to detect and prevent illegal activity; and conducting pre-award and post-award reviews of VA's Federal Supply Schedule contracts and contracts for health care resources awarded by VA medical facilities.

VA spends over $6 billion annually for supplies, services, construction, and equipment. Systemic problems in planning, defining requirements, and managing acquisitions supporting major system development initiatives along with weaknesses in all phases of contract award and administration have impacted VA's ability to effectively acquire the goods, services, and systems it needs. The OIG continues to identify contracts that do not adequately protect the Government's interest. These contracts result in large dollars losses to VA as well as jeopardizing the success of the Department's programs. We continue to see systemic deficiencies that include the lack of effective communication, little or inadequate acquisition planning, poorly written statements of work, inadequate competition, and poor contract administration. These deficiencies have led to services being ordered that the customer did not want, procurement goals not being satisfied, and VA paying inflated prices. We will expand our oversight of these issues, especially with respect to construction, which will be reviewed to

assess contract and project management to ensure VA receives reasonable prices and acceptable performance.

It is difficult for VA to effectively manage its contracting activities since it has no corporate database that provides national visibility over procurement actions or identifies contract awards, individual purchase orders, credit card purchases, or the amount of money spent on goods and services. Without this capability, VA does not know what it has purchased, from whom, whether it met competition requirements, and whether prices paid are fair and reasonable. VA recently began to implement a nationwide information system, electronic Contract Management System (eCMS), to capture contracting action. We will assess whether VA contracting entities comply with related policies and procedures, especially whether the data entered into the system is accurate and complete. Although compliance will provide VA with more information regarding the number and type of contracts awarded, it will not ensure that contracts are in the best interest of the Government or compliant with procurement laws and regulations. In addition to assessing the information system needed to capture procurement data, we will assess the need for developing metrics and standards to monitor and measure acquisition workload, performance, and purchasing throughout VA.

Information Management

VA continues to struggle with the need to establish and maintain strong information security controls. The Federal Information Security Management Act (FISMA) mandates an annual review of information security management policies and practices. This review has identified systemic issues and resulted in numerous recommendations that will require a significant amount of management attention and time. We will continue to follow up on the continuing information security control problems identified in our annual FISMA audits.

A broader concern than IT security is VA's need to improve its IT governance since OMB currently lists numerous VA systems, with a FY 2007 operating budget of about $349 million, on its management watch list. Ongoing audit work indicates that the number of at-risk systems could be understated because VA needs to improve the accuracy and reliability of its major IT investment information. The multi-million dollar failure of VA's Core FLS system development underscores the challenges associated with effective IT governance. VA's current initiatives to implement a new financial and logistics management system will also face significant risk of cost overruns, performance problems, and delays if VA does not address the lessons learned from the Core FLS system development initiative. Finally, VA has faced numerous problems in the protection of personally identifiable information that is subject to privacy laws and regulations, and while VA has issued additional policy guidance to address many of these concerns, we will continue to monitor and report on compliance.

CONCLUSION

OIG independent oversight provides VA and Congress with an objective assessment of the important issues and challenges facing VA in delivering benefits and services to veterans. In closing, I would like to add that we will always focus available resources on the most urgent issues. However, OIG oversight of issues such as large data loss cases and those at the Marion

VAMC are examples of reactive work that were not planned for. These reviews are very labor intensive and require us to postpone or cancel other planned or ongoing priority work.

OIG oversight is not only a sound fiscal investment; it is an investment in good government. While I truly believe we have added value to VA, I also believe that we have only scratched the surface on what we can accomplish. VA is faced with evolving challenges. If the OIG is to remain an agent of positive change, we must be able to increase our level of oversight. To accomplish this, resource levels need to be commensurate with this challenge.

Thank you again for the opportunity to appear before this committee. We would be pleased to answer your questions.