STATEMENT OF THE OFFICE OF INSPECTOR GENERAL
BEFORE
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON THE FISCAL YEAR 2009 BUDGET FOR THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

FEBRUARY 27, 2008

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to address the fiscal year (FY) 2009 budget for the Office of Inspector General (OIG). This testimony will outline recent accomplishments and discuss how we would invest budget resources in FY 2009 to provide independent and objective oversight of Department of Veterans Affairs (VA) mission-critical activities and programs in health care delivery, benefits processing, financial management, procurement practices, and information management.

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 FY 2007, OIG funding supported 440 full-time equivalents (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 FY 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 FY 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 the Department of Defense (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 (VAMC).

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.

Additionally, we testified before Congress during the past calendar year 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.
- VA's Strategic Mental Health Plan.

RESOURCES

For FY 2008, OIG funding is $80.5 million, which includes $7.9 million in emergency funding authorized by the President. This funding supports 488 positions, for an increase of 48, which is allocated as follows:

Office of Healthcare Inspections	15
Office of Investigations	14
Office of Audit	4
Office of Management and Administration	12
Office of the Counselor to the Inspector General	3

We are very appreciative of this funding and we already have launched an aggressive recruiting effort to fill these positions. For FY 2009, the budget submitted for the OIG is $76.5 million, which supports 440 FTE.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) reviews the quality of health care provided to veterans in VA hospitals, clinics, and nursing homes, in addition to the care provided to veterans through various health care contracts. In FY 2009, OHI will have 57 FTE in eight locations throughout the country; this is a decrease of 15 from FY 2008. The staff includes 5 physicians, a psychologist, a mathematical statistician, and 43 health care inspectors who are primarily nurses or social workers.

OHI workload is divided into two main categories – proactive and reactive work. Proactive work includes CAP reviews of medical centers that are conducted on a 3-year cycle. For those facilities that we believe are at risk, we may review them in consecutive years. These reviews focus on ensuring that medical centers have procedures in place and comply with VA policy to ensure that veterans receive quality health care. In FY 2009, CAP reviews will focus on quality management, credentialing and privileging, nurse staffing, medication management, coordination of care, discharge planning, environment of care, and emergent care. We plan to publish 45 CAP reports in FY 2009.

OHI also conducts health care inspections on a national scope of significant issues. Two examples of national reports are *Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities,* and *Healthcare Inspection Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. In FY 2009, we plan to publish nine national reports.

Reactive work comes from allegations that we receive through a variety of sources, including Congress, the OIG Hotline, and VA. Because of the volume of work, we are unable to accept all cases and as such we must refer many to VA for review. We plan to publish 45 Hotline reports in FY 2009.

During FY 2009, we will focus on the following issues:

- Quality of Care Controls – OHI's primary focus is the quality of health care that veterans receive. In June 2007, OHI published a report on the care provided at the Martinsburg, West Virginia, VAMC where a patient died from the lack of a functioning airway. In August 2007, OHI reported on our follow-up experience with the surgery service quality of care issues at the Salisbury, North Carolina VAMC. In December 2007, we reported on significant management deficiencies in the Intensive Care Unit at the San Antonio, Texas VAMC. In January 2008, OHI reported on the quality of care issues at Marion, Illinois VAMC. OHI is concerned that VHA quality controls, including the peer review process, are not functioning correctly to ensure that veterans receive quality health care. We plan to review compliance with VHA's new peer review policy in FY 2009.

Our Marion review also identified deficiencies in the credentialing and privileging process, such as the failure to document consideration of important information including malpractice claims, the health status of a surgeon, and information in references. In the privileging area, we found instances in which physicians were privileged to perform procedures without any documentation of current competence to perform those procedures. Based on this information, we plan to expand the review of credentialing and privileging actions taken at the local facilities during our CAP reviews. We will also compare the intensity 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. This analysis will include a review of the distribution of complex cases between VA provided care and fee basis care.

- OIF/OEF Veteran Health Care Issues – Veterans who have returned from recent conflicts experience two medical traumas with great frequency: Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). OHI 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 also will continue to review the effectiveness of the transmission of health records between DoD and VA.

- Specialty Medical Care Access and VAMC Capabilities – VA has over 800 community based outpatient clinics (CBOCs) that provide medical care to veterans who reside some distance from a VAMC, especially those in rural areas. We will review the care that veterans receive at CBOCs and through the fee basis system.

  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 medical center and that available at a 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 national review.

- Medical Care for Elderly Veterans – OHI 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. The 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. OHI will build on a 2006 report on access to care and CAP reviews to evaluate these programs.

- Homeless and Other Non-Healthcare Programs – OHI will continue to review programs designed to assist veterans who are at great risk because of their homelessness or other lifestyle characteristics. We will build on our reports in the

past on homeless veterans care programs, aid and assistance programs, and similar efforts through a national project designed to highlight the impact of current programs.

Additional high priority areas that would benefit from OIG oversight include health care services provided at the 200 Vet Centers, where veterans may not receive the same standard of care that they would receive at a primarily medical clinic.

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 future oversight.

OFFICE OF INVESTIGATIONS

The Office of Investigations (OI) conducts criminal and administrative investigations of wrongdoing in VA programs and operations, and seeks prosecution, administrative action, and monetary recoveries as it strives to establish an environment in VA that is safe and free from criminal activity and management abuse. Subjects of investigative oversight includes VA employees and contractors, and anyone else committing crimes against VA.

For FY 2009, OI is authorized 149 FTE, which is 14 less than FY 2008. This includes 124 criminal and administrative investigators located at 25 locations throughout the country. With the resources budgeted in FY 2009, OI expects to conduct about 1,100 criminal investigations with a result of about 1,700 arrests, indictments, convictions, administrative sanctions, and pre-trial diversions. OI also expects to achieve over $100 million in fines, penalties, restitutions, and civil judgments. Priority will be on investigating allegations of criminal activity associated with health care, benefits, information management, financial management, and procurement.

Health Care

Most investigations of fraud, waste, and abuse in VA health care programs come to the attention of OI from various sources, including veterans and employees. In FY 2009, OI expects to conduct 230 criminal investigations in the following health care related areas.

- Patient abuse, which includes homicides, assaults, rapes, robberies, and threats.

- Drug diversion, which includes employees stealing from patients, employees stealing from the pharmacy, illegal use of prescription pads, family members not reporting the death of veteran in order to continue to receive controlled prescription drugs, and theft of drugs mailed to veterans from the Consolidated Mail-Out Pharmacy.

- Identify theft, which includes individuals stealing veterans' identities to get free health care.

- Drug distribution, which includes veteran patients illegally selling their prescription drugs, and drug dealers on VA property selling "street drugs."

Benefits Fraud

OI will continue to aggressively pursue leads that provide indications of fraudulent and criminal activity across VA benefit programs. In addition to responding to allegations, OI will also utilize several proactive data matching initiatives to reduce erroneous payments and deter benefits fraud. OI expects to complete approximately 585 benefits fraud cases in FY 2009. Examples of benefits fraud investigations include:

- Theft of monetary benefits from fiduciaries or survivors of deceased veterans.

- Those who fabricate or grossly exaggerate symptoms to obtain disability compensation benefits they would otherwise not be entitled to receive.

- Individuals who steal the identity of a veteran to illegally obtain compensation and pension, education, and housing benefits.

- Stolen Valor, which is using unearned medals of valor, such as the Purple Heart, to illegally obtain benefits.

OI will also initiate several proactive computer matching initiatives to detect and deter criminal activity. For example, the Fugitive Felon Program involves computerized matches between fugitive felon files of Federal and state law enforcement organizations and VA benefit files. When a veteran fugitive felon is identified, VA suspends benefits and initiates recovery of any benefit payments made while the veteran was in fugitive status. To date this program has resulted in 1,700 arrests, of which 112 were VA employees. Reported monetary benefits exceed over $1 billion.

The Death Match Program compares the Social Security Administration's "Death File" with a database of VA beneficiaries, which enables us to identify instances of benefits continuing to be paid out to deceased veterans. OI work in this area focuses on investigating and prosecuting those individuals taking advantage of a beneficiary's death for personal gain. This program has resulted in more than 250 arrests, recovery of more than $27 million, and a 5-year cost avoidance of more than $72 million. In addition, the Defense Manpower Data Center Program matches certain VA records with DoD military records in an effort to verify eligibility for VA benefits. These matches provide valuable leads in Identity Theft and Stolen Valor cases.

Other Criminal Activity

An additional 285 criminal investigative cases related to financial, information technology (IT), and procurement fraud are also expected to be performed in FY 2009. OI will assist in the assessment of new financial management systems, particularly the degree to which they influence the likelihood of VA suffering financial crimes, and will aggressively pursue and prosecute any illegal activity discovered. In the area of procurement, OI will continue to review purchase card activity data to identify unusual purchase activity such as transactions processed at pawnshops, art galleries, liquor stores, massage parlors, and other unexpected places. Purchases at these places will be investigated and prosecuted if determined to be fraudulent. OI will also investigate allegations of criminal activities associated with acquisition and maintenance of IT supplies and services, and unlawful access and use of information systems and IT resources. OI will continue to investigate major data breach cases such as the recent incident at the Birmingham VA Medical Center that involved the loss of an external hard drive containing personal identifiers of approximately 1.6 million veterans and health care providers.

In order to help deter crime, criminal investigators will provide fraud awareness briefings to about 30,000 employees at VA facilities nationwide. These briefings have resulted in additional referrals of alleged criminal activity and have greatly improved our partnership with the VA police in helping provide a safe and secure environment for veteran patients and employees.

In addition to criminal investigations, OI also conducts administrative investigations of allegations of misconduct by senior VA managers. These allegations include such issues as use of public office for private gain, inappropriate use of resources, nepotism, and creating a hostile work environment. During FY 2009, OI expects to issue about 15 administrative investigative reports with recommendations for appropriate administrative action.

OFFICE OF AUDIT

The Office of Audit conducts independent financial and performance audits that address the economy, efficiency, and effectiveness of VA operations. For FY 2009, the Office of Audit is authorized 175 FTE, which includes a professional staff of 164 in nine locations across the nation. The FY 2009 level is a loss of four from FY 2008.

We perform three mandatory audits and reviews in the financial management area: the audit of VA's consolidated financial statements, the annual review of VA's statement on the use of drug control monies, and an annual review of VA's report on its capacity to treat special disabilities such as mental health disorders, traumatic brain injury, and spinal cord injuries. We also perform mandatory work under the Federal Information Security Management Act (FISMA). These annual reviews of information security management policies and practices have identified systemic issues and resulted in numerous recommendations.

In addition to our mandatory work in FY 2009, we plan to issue 23 national audits related to the following strategic areas. These audits are expected to report $100 million in monetary benefits.

- Health Care Delivery – 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. In FY 2009, we will issue three reports on clinical services resource allocation, outpatient scheduling processes, and controls and safeguards in domiciliary residential rehabilitation and treatment programs.

- Benefits Processing – VA provides benefits and services to over 3.7 million veterans and beneficiaries including returning OIF/OEF veterans, veterans with chronic progressive conditions, and the aging veteran population. We plan to assess the timely and accurate provision of benefits to veterans, particularly veterans returning from OIF/OEF. In FY 2009, we will issue six reports on benefit processing training programs, compensation and pension disability rating systematic technical accuracy review program, compensation and pension disability examinations, controls over VBA regional office operations, veterans housing assistance program risk management processes, and independent living services for veterans with service-connected disabilities.

- Financial Management – VA continues to face major challenges in financial management as it lacks an integrated financial management system and has material weaknesses that impact VA's ability to safeguard and account for financial operations. In addition to our mandatory work, we will issue four reports in FY 2009 on implementation of the financial logistics integrated technology enterprise system (FLITE), VHA integration of budget and performance management with the Veterans Equitable Resource Allocation System, VHA Chief Business Office's oversight of the fee basis program, and the Medical Care Collection Fund billing and collection activities.

- Procurement Activities – VA cannot effectively manage its contracting activities because 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. We and the Government Accountability Office have identified significant and persistent deficiencies in VA's procurement activities. In FY 2009, we will issue six reports on Veterans Integrated Service Network acquisition of supplies and non-clinical services, standardization initiatives for medical supplies and pharmaceuticals, oversight and management of community nursing home contracts, implementation issues in the electronic contract management system, capital asset management system, and acquisition of high-cost medical equipment.

- Information Management – In addition to our FISMA work, we are concerned about VA's IT governance especially since the FY 2007 operating budget for IT was approximately $349 million. In FY 2009, we plan to expand our national audit coverage to help identify and address security vulnerabilities inherent in VA operations and issue four reports. This includes reports on controls over sensitive electronic veterans' health care data, Health*e*Vet system development, appointment scheduling system development issues, and enterprise architecture.

Additional high priority areas that would benefit from OIG oversight include accuracy of disability claims decisions, process for enrolling veterans for health benefits, security of data exchanges with DoD, timeliness and quality of prosthetics provided to veterans, and activation of major construction projects

OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) conducts pre-award, post-award, drug pricing, and special reviews of vendor's proposals and contracts. It is staffed by 25 auditors and analysts through a reimbursable agreement with VA's Office of Acquisition and Logistics. The majority of reviews are related to Federal Supply Schedule (FSS) contracts awarded by the VA National Acquisition Center for pharmaceutical, medical and surgical supplies, and equipment; and contracts for health care resources awarded by VA medical facilities. Since FY 2002, OCR has issued 420 reports with a total monetary impact of $2.1 billion.

Pre-award reviews are required for both FSS and health care resources proposals where the estimated contract costs exceed predetermined dollar thresholds. The pre-award reviews provide valuable information to assist VA contracting officers in negotiating fair and reasonable contract prices. OCR verifies that the pricing and other data submitted by the vendor to the contracting officer is accurate, complete, and current by verifying the information directly to the vendor's accounting records and information systems.

OCR continues to identify information submitted by vendors that is not accurate, complete, and current that would result in VA paying inflated contract prices. Also, OCR continues to identify the lack of communication between procurement and program officials and inadequate planning as a management challenge for health care resources contracts. The lack of communication and poor planning results in higher and unnecessary contract costs because requirements have not been properly identified, the statement of work is inadequate, and the estimated quantities are overstated. We also routinely find that VA's health care resources contracts lack adequate oversight provisions to ensure VA has received the services that it has paid for. In FY 2005, OIG issued a report that highlighted the systemic issues in health care contracting. While VA has made progress, we continue to identify the same or similar issues. During FY 2009, OCR plans on conducting 45 pre-award reviews.

Post-award reviews are conducted to determine if a contractor submitted accurate, complete, and current pricing data to the contracting officer during negotiations as required by the terms of the contract and also to ensure the vendor adhered to other terms and conditions of the contract such as the Price Reductions Clause. The post-award reviews also include OCR's efforts to ensure pharmaceutical vendors are in compliance with statutory drug pricing provisions contained in Section 603 of P.L. 102-585, the Veterans Health Care Act of 1992, which sets statutory price limits of covered drugs for DoD, VA, the Public Health Service, and the United States Coast Guard. Since October 2002, post-award reviews have resulted in $80.2 million in actual recoveries to VA. These monies are returned to the VA Supply Fund. OCR's post-award program is a significant factor in the success of VA's voluntary disclosure program where a vendor can disclose non-compliance with contract terms and conditions that resulted in the Government overpaying for goods or services. These voluntary disclosures are typically resolved administratively but are referred to the Department of Justice if warranted. Since FY 2002, OCR has received 75 voluntary disclosures representing $60.1 million of the $80.2 million in recoveries since FY 2002. In a majority of the voluntary disclosure reviews, OCR found the proposed refund to VA was understated. In FY 2009, we plan to conduct 25 post-award reviews.

Also, OCR is routinely asked to conduct special reviews of contracts awarded by VA in areas other than FSS or health care resources. These reviews are requested by Congress, VA, or as a result of OIG Hotline contacts. Many of these projects involve large dollar procurements. OCR finds many of the same issues that have been already identified such as the lack of effective communication, inadequate acquisition planning, poorly written statements of work, inadequate competition, lack of documentation of fair and reasonable pricing, poor contract administration, and inadequate technical reviews. These deficiencies have led to services being ordered that the customer did not want, the goal(s) of procurements not being satisfied, VA paying inflated prices, and even duplicate orders being placed for the same deliverables. While VA has made steps in the right direction such as establishing the Contract Review Board and the VA Electronic Management System, it is too early to determine if these tools will be effective. For FY 2009, we plan on performing five special reviews.

For FY 2009, OCR plans on continuing efforts in all areas to strengthen VA's procurement process and provide the necessary data to management and contracting officials to negotiate and administer VA's contracts in an effective and efficient manner.

Our pre-award workload is ultimately dependent on the proposals that exceed the dollar threshold for audit and determines the resources available to conduct post-award reviews. The priority of reviews does change depending on special review requests from VA's management which ultimately impacts the total number of reports to be issued. Most special reviews are extensive reviews of individual contracts with short deadlines. OCR constantly assesses and prioritizes the reviews to meet these demands.

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, we 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 we truly believe we have added value to VA, we 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.