Statement of Richard J. Griffin
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Budget Requests for Fiscal Year 2011
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Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the budget request for fiscal year (FY) 2011 for the Office of Inspector General (OIG). I am accompanied today by Mr. James J. O'Neill, Assistant Inspector General for Investigations; Ms. Belinda Finn, Assistant Inspector General for Audits and Evaluations; Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; and Ms. Maureen T. Regan, Counselor to the Inspector General.

ACCOMPLISHMENTS

As an overview, in FY 2009, the OIG identified $2.931 billion in actual and potential monetary benefits; issued 235 reports on VA programs and operations; and achieved 539 arrests, 303 indictments, 186 criminal complaints, 367 convictions, 809 administrative sanctions, and 46 pretrial diversions. The OIG return on investment is $38 in monetary benefits for every $1 invested in OIG investigations, audits, and contract reviews.

Some of our noteworthy accomplishments in the past year include:

- A national review on improper disinfection of endoscopes that resulted in VA making major changes in training, purchasing, and organizational structure and will make endoscopic procedures safer at VA facilities.
- An audit that found 37 percent of fee basis payments were improper and recommended changes to improve the accuracy of payments that could reduce over $1 billion in improper payments.
- An audit that identified how the Veterans Benefits Administration (VBA) could substantially reduce the time veterans wait for a decision on their claims; when implemented, VBA could reduce 187 days from their processing time for claims pending over 365 days.

- An investigation that resulted in the first successful felony conviction of a company's chief executive officer for off label marketing of pharmaceuticals, and another off label marketing investigation that resulted in a major pharmaceutical manufacturer agreeing to pay $2.3 billion, the largest health care fraud settlement in Department of Justice history.

In FY 2009, we also testified before Congress on the following topics:

- Shredding and mishandling of documents at VA Regional Offices (VAROs).
- Challenges facing VA in FY 2010.
- VA's Mental Health Strategic Plan.
- VA's endoscopy procedures.
- VHA's quality management program.
- VA's interagency agreement with the Space and Naval Warfare Systems Center.
- VA's pharmacy benefits program.
- Senior Executive Service bonuses and other administrative issues.

Also in FY 2009, our Office of Audits and Evaluations and our Office of Investigations received the highest rating possible in their respective external peer reviews. The Comptroller General's *Government Auditing Standards* and the Council of the Inspectors General on Integrity and Efficiency require that audit and investigative offices be reviewed every 3 years by other OIGs.

For FY 2011, the President's budget has requested $109,367,000 for the OIG which amounts to less than current services. We intend to reprioritize projects planned in 2010 and 2011 and to achieve contracting efficiencies to enable us to complete our mandatory work and to the extent possible, perform reactive work requested by Congress and the VA Secretary.

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 our investigations include VA employees and contractors, and anyone else committing crimes against VA.

In 2011, OI expects to conduct about 1,200 criminal investigations with a result of approximately 2,000 arrests, indictments, convictions, administrative sanctions, and pre-trial diversions. OI also expects to achieve over $300 million in fines, penalties, restitutions, civil judgments, and cost savings. 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 2011, OI expects to conduct 350 criminal investigations in the following health care related areas:

- Patient abuse, which includes homicides, assaults, and sexual assaults.
- Thefts, robberies, and threats at VA medical facilities.
- 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 a veteran in order to continue to receive controlled prescription drugs, and theft of drugs mailed to veterans from the Consolidated Mail-Out Pharmacies.
- Identity theft, which includes individuals stealing veterans' identities to get VA 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 600 benefits fraud cases in 2011. Examples of benefits fraud investigations include:

- Theft of monetary benefits by fiduciaries or survivors of deceased veterans.
- Those who fabricate or grossly exaggerate either military service or disabilities 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.

OI will also conduct 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 can suspend benefits and initiate recovery of any benefit payments made while the veteran was in fugitive status. Since its inception in 2002, this program has resulted in 2,006 arrests, of which 138 were VA employees. Reported monetary benefits exceed $1.4 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 382 arrests, recovery of more than $40 million, and a 5-year cost avoidance of more than $113 million.

Other Criminal Activity – An additional 250 criminal investigative cases related to financial, information technology (IT), and procurement fraud, as well as employee theft and threats against VA employees and facilities, are also expected to be conducted in

2011. In the area of procurement, OI expects to devote additional resources to uncovering fraud in the Service-Disabled Veteran-Owned Small Business program and contracts funded by the American Recovery and Reinvestment Act of 2009 (ARRA). 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.

In addition to criminal investigations, OI also conducts administrative investigations of allegations of serious misconduct by senior VA managers. These allegations include such issues as use of public office for private gain, inappropriate use of resources, nepotism, and hiring irregularities. During 2011, OI expects to conduct 25 administrative investigations and issue reports with recommendations for appropriate administrative action when allegations are substantiated.

OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations conducts independent financial and performance audits and inspections that address the economy, efficiency, and effectiveness of VA operations. Our efforts focus on providing independent assessments that focus on accountability for achieving results and provide oversight over all VA programs, operations, and business processes.

In 2009, we established a Benefits Inspection Program to help ensure veterans receive timely and accurate benefits and services. Our independent inspections provide recurring oversight of VA Regional Offices (VAROs) by focusing on disability compensation claims processing and performance of Veterans Service Centers operations. We performed six inspections focusing on VSC operations in the areas of claims processing, data integrity, management controls – including date stamping and review of the implementation of a new policy regarding shredding and information security. In addition we focused on the timeliness and accuracy of VBA's Public Contact teams, who provide information in response to veterans, beneficiaries, and congressional requests. In 2010, we could perform 18 benefits inspections by establishing a second Benefits Inspections Division. Once this second division is staffed, we could expand the number of inspections so that we can establish a 3-year inspection cycle. Further, we plan to perform follow-up inspections at VAROs experiencing persistent performance issues and management challenges.

We also expect to continue our oversight of VA's ARRA funds through 2010 and 2011, which is consistent with VA's spending plans for the $1.4 billion that they received under ARRA.

Mandatory Work – Annually, we perform mandatory audits and reviews in financial management areas such as VA's consolidated financial statements, VA's statement on the use of drug control monies, and the Federal Information Security Management Act (FISMA). These reviews of information security management policies and practices have identified systemic issues and resulted in numerous recommendations and opportunities to strengthen enterprise security deficiencies. While VA has made

progress in its efforts to safeguard sensitive information, significant oversight is still needed in this area because VA has yet to improve and remediate about 8,000 enterprise-wide security deficiencies. Further, independent assessments are needed to ensure VA actions to eliminate these weaknesses are effective.

In addition to our mandatory work in 2011, we plan to issue 20 national audits related to the following strategic areas. These audits are expected to identify opportunities for better use of funds and to identify monetary benefits exceeding $340 million.

Health Care Delivery – Budgeting, planning, and resource allocation in VA are extremely complex, and remain 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.

Benefits Processing – In FY 2011, VBA is expected to provide compensation and pension services to over 3.8 million veterans and beneficiaries including returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, veterans with chronic progressive conditions, and the aging veteran population. Our inspection work will identify trends and risk areas that need further review on a system-wide level. We also expect to follow up on the deployment of an automated system for processing applications under the Post 9/11 GI Bill; we anticipate focusing on the accuracy and timeliness of payments in that program.

Financial Management – VA faces 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. Given the significant financial investment VA is making in the development and implementation of a new financial logistics integrated technology enterprise system (FLITE) we will continue our oversight of system development and related financial activities.

Procurement Activities – VA cannot effectively manage its contracting activities because it has not leveraged or fully embraced the VA Electronic Contract Management System that can provide national visibility over procurement actions and identify contract awards, individual purchase orders, credit card purchases, and the amount of money spent on goods and services. We are also concerned about VA's vendor identification and contract award processes for Service-Disabled Veteran-Owned Small Businesses.

Information Management – IT management is a high risk area that VA has clearly struggled to manage effectively. In addition to our FISMA work, we are concerned about VA's IT governance and capital planning along with the overall management of its IT investment portfolio. VA will be challenged to effectively manage high cost IT projects such as the paperless claims processing initiative, Post 9/11 GI Bill, and Health*e*Vet, which are slated to receive $145.3 million, $100 million, and $346.2 million, respectively, in VA's FY 2011 proposed budget.

Unfortunately, there are several high priority areas that would benefit from OIG oversight but that we will not be able to address. These include evaluating the effectiveness of VBA's Appeals Management Center and VBA's workload management systems, the process for enrolling veterans for health benefits, timeliness and quality of prosthetics provided to veterans, and the activations and management of major construction projects.

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. OHI workload is divided into two main categories – proactive and reactive work. Proactive work includes our Combined Assessment Program (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. We plan to publish 55 CAP reports in 2011.

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. In addition to reviewing medical centers, OHI reviews CBOCs to ensure that processes are in place to ensure veterans receive high quality health care. The CBOC inspection process consists of four components: (1) CBOC site-specific information gathering and review, (2) medical record reviews for determining compliance with Veterans Health Administration (VHA) performance measures, (3) onsite inspections, and (4) CBOC contract review. We plan to complete 40 reviews in 2010 and to increase that to 80 in 2011; these plans may be scaled back, however, if other higher priority work arises.

OHI also conducts health care inspections on a national scope addressing significant issues. Two examples of national reports are *Healthcare Inspection – Readjustment Counseling Service Vet Center Report*, and *Review of Informed Consent in the Department of Veterans Affairs' Human Subjects Research*. In 2011, we plan to publish 10 national reports.

Reactive work comes from allegations that we receive through a variety of sources, including Congress, the VA Secretary, and the OIG Hotline. Because of the volume of work, we are unable to accept all cases of credible allegations for independent review, and refer many to VA for review, fact-finding, and corrective action. OHI expects to publish 45 reports in 2011.

During 2011, we will focus on the following issues:

Quality of Care Controls – Several reports published in early FY 2010 indicate that issues remain in VHA's quality management program. We will continue to monitor and review VHA's controls in 2010 and 2011.

The OIG has been concerned about the quality of medical care from non-VA sources, when medical care is purchased via contract or fee basis programs. Current work on brachytherapy treatments for prostate cancer indicates that contracts to procure veteran health care may not contain requirements to share outcome data. Several CBOC reports from 2010 demonstrate that where CBOC contracts are in place, effective oversight of the contracts may be lacking. OHI will undertake a body of work to address these deficiencies in 2011.

OIF/OEF Veteran Health Care Issues – Veterans who have returned from recent conflicts experience two medical traumas with great frequency: Traumatic Brain Injury and Post Traumatic Stress Disorder. OHI has reported on the mental health issues of this population through individual care reports and through programmatic reviews. In March 2009, OHI reported on *Access to Mental Healthcare in Montana* by veterans, and found access, using a drive time standard, was good as VA had partnered with community mental health clinics to supplement VA facilities; however there was an unmet need for substance abuse treatment. In 2010 and 2011, the OIG will report on issues related to the diagnosis, treatment, and disability compensation for female veterans of OIF/OEF and related projects.

Medical Care for Elderly Veterans – OHI will publish a report on elderly veterans who are at special risk of harm because of their age, medical conditions, and living arrangements in February 2010. In 2011, OIG plans to review aspects of VA's nursing home program.

Homeless and Other Non-Healthcare Programs – Additional high priority areas that would benefit from OIG oversight include programs designed to assist veterans who are at great risk because of their homelessness or other lifestyle characteristics. With $4.2 billion in VA's FY 2011 budget for homeless veteran programs, we would like to build on past reports, such as our June 2009 review of VA residential mental health care facilities, including domiciliary facilities. However, we have not been able to review programs such as health care and supportive care for homeless veterans and VHA elder care as consistently or as thoroughly as they warrant.

OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) conducts pre-award, post-award, drug pricing, and special reviews of vendor proposals and contracts through a reimbursable agreement with VA's Office of Acquisition, Logistics, and Construction. 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 2005, OCR has issued 463 reports with a total monetary impact of $1.9 billion. In 2011, OCR plans on issuing 75 reports with monetary benefits of approximately $300 million.

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 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. During 2011, OCR plans on conducting 50 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 VA, the Department of Defense, the United States Public Health Service, and the Coast Guard. Since October 2005, post-award reviews have resulted in $116 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. In 2011, we plan to conduct 25 post-award reviews.

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, the VA Secretary, 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 goals of procurements not being satisfied, VA paying inflated prices, and even duplicate orders being placed for the same deliverables. While VA has taken steps in the right direction such as establishing the Contract Review Board and the VA Electronic Contract Management System, these tools have yet to prove their effectiveness.

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

OUTREACH ACTIVITIES

The OIG also proactively assists in the training of VA leaders and employees through the following efforts:

- To increase awareness of the OIG's mission and work, we make presentations to participants at VA's premier leadership development program, Leadership VA; to new managers at VBA's Management Academy; and on a biweekly basis to all newly hired employees at VA Central Office.
- To help deter crime, criminal investigators provide fraud awareness briefings to about 10,000 employees annually 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.
- To strengthen VA procurement, OCR provides training to VA's contracting officers at the Acquisition Training Academy in Frederick, Maryland.
- To improve the management of VA medical centers, we present information on OIG review processes and past findings at VHA's program for new medical center leaders.

CONCLUSION

The OIG provides Congress, the VA Secretary, and taxpayers with independent oversight of VA's programs and operations. We believe the OIG is a sound fiscal investment. We will continue to be flexible so as to focus our resources on the most urgent issues facing VA. However, OIG oversight of issues such as the review of endoscopy equipment is reactive work that is labor intensive and requires us to postpone or cancel other ongoing or planned work.

Thank you for the support you have shown the OIG and the opportunity to testify today. We would be pleased to answer your questions.