



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES
LEGISLATIVE HEARING ON
H.R. 2428 AND OTHER PENDING LEGISLATION
APRIL 21, 2021

Chairman Pappas, Ranking Member Mann, and Subcommittee Members, thank you for giving the Department of Veterans Affairs (VA) Office of Inspector General (OIG) the opportunity to discuss H.R. 2428, which would strengthen OIG oversight of VA programs and operations. The bill would enable the OIG to obtain relevant information from individuals who are not employed by VA. My statement on behalf of the OIG provides an analysis of the measure before the Subcommittee today and highlights prior OIG work in which testimonial subpoena authority would have made a significant impact. I will also provide information on several other bills under consideration today that relate to OIG report findings.

VA OFFICE OF INSPECTOR GENERAL

The OIG's mission is to improve the lives of veterans and serve the public by conducting meaningful, independent oversight of the programs and operations of VA through audits, inspections, investigations, and reviews. The OIG also recommends improvements in VA programs and operations and acts to deter, detect, and address fraud and other crimes, waste, and abuse.

The OIG is staffed with more than 1,000 employees and has its principal investigation and oversight activities organized within four offices:

- Investigations
- Special Reviews
- Audits and Evaluations
- Healthcare Inspections

In addition to the Washington, DC, headquarters, the OIG has approximately 50 offices throughout the country. OIG staff and leaders are grateful for Congress's recognition of the OIG's oversight work through increased routine appropriations and additional funding under the Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act) and the American Rescue Plan.

H.R. 2428 ANALYSIS

The Strengthening Oversight for Veterans Act of 2021, H.R. 2428, would give the VA Inspector General the authority to require by subpoena the testimony the OIG deems critical to performing its authorized oversight functions.

The OIG supports this bill because it would give OIG personnel an important tool to conduct comprehensive and effective oversight of VA's activities. It is critical that OIG staff consider all available information from individuals with knowledge of serious misconduct, fraud, and inefficiencies that affect the delivery of care and other services and the effectiveness of financial support to veterans and their families, as well as their safety. Testimonial subpoena authority would strengthen the OIG's ability to gather information about potential fraud, waste, and abuse related to VA programs and activities—information that is essential for VA to hold responsible individuals accountable. This authority would not apply to criminal proceedings.

Under present authorities, the OIG can obtain documents and other materials from VA and other federal agencies and can subpoena such records from nonfederal individuals and entities. The OIG also may compel VA employees and contractors to speak with OIG staff in connection with the OIG's work, except when an individual claims constitutional protection against compelled self-incrimination.¹ However, the OIG has no mechanism to compel former federal employees or other individuals outside the government with potentially relevant information to provide testimony in support of OIG oversight activities. H.R. 2428 would give the OIG the authority to obtain sworn statements from such individuals, including former federal employees, former employees of current federal contractors, employees of former federal contractors, and others with relevant knowledge who do not have an employment or contractual relationship with VA.

This authority would entrust the VA OIG with the same ability afforded other OIGs that conduct oversight of large healthcare delivery and contracting organizations: the Department of Defense and the Department of Health and Human Services.² The Pandemic Response Accountability Committee created by the CARES Act to provide oversight of \$2.2 trillion in government funds was also provided with testimonial subpoena authority.³ The OIG recognizes the gravity of employing this authority and is committed to using it prudently.

This legislation contains four important external checks and tracking mechanisms to ensure the OIG makes responsible use of the authority. First, it requires the OIG to provide the proposed witness notice of its intent to issue a subpoena, and the opportunity for the witness to testify voluntarily. Second, it

¹ For VA employees, *see* 38 C.F.R. § 0.735-12(b). For contractors, *see* Federal Acquisition Regulation, 48 C.F.R. § 52.203-13.

² For Department of Defense authorities, *see* 5 U.S.C. App 3 § 8. For Department of Health and Human Services authorities, *see* 42 U.S.C. § 1320a-7a(j).

³ Pub. L. No. 116-136, 134 Stat. 281, § 15010(e)(3)(A)(ii).

requires the OIG to notify the U.S. Attorney General before issuing a subpoena and gives the Attorney General up to 10 days to object if the subpoena might interfere with an ongoing investigation. Third, it mandates that the OIG endeavor to arrange the interview in a location convenient to the witness. Fourth, the legislation requires the OIG to include in its semiannual report to Congress the number of testimonial subpoenas issued, the number of individuals interviewed pursuant to the subpoenas, the number of times the Attorney General objected to the issuance of a subpoena, and any other matters the OIG considers appropriate related to this authority.

The lack of subpoena authority for witness testimony has hampered prior efforts to provide comprehensive oversight. The following are examples of occasions on which OIG personnel have been unable to fully analyze potential wrongdoing because they were unable to interview essential participants who were not government employees or had left federal employment before or during the OIG review.

Example 1. Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist

An OIG healthcare inspection team evaluated deficiencies identified in the practice and oversight of a radiologist working on a fee basis during a six-month period regarding the radiologist's credentials and provision of inadequate health care, and the facility's delayed evaluation of that care.⁴

The OIG reported that when the radiologist began providing services in 2014, the chief of imaging, the radiologist's supervisor, conducted inadequate oversight. On finally reviewing the radiologist's work, the chief noted it was "unsatisfactory" and raised concerns about the radiologist's diagnostic interpretations. The facility did not review the radiologist's work until after 2016 and did not alert regional leaders to the clinical failures until 2018, after the OIG had already identified concerns with the radiologist's work. In the interim, the radiologist left the facility, preventing OIG staff from compelling testimony and conducting a more complete review of the clinical failures. Two patients received disclosures from the facility that an adverse event had resulted from the radiologist's deficient practices, and dozens of other images were not read to standard. The OIG's work would have benefited from the radiologist's testimony on the facility's oversight process and insight on how clinical failures went undetected.

Example 2. Alleged Improper Release of Procurement Information

The OIG investigated allegations that current and former VA employees provided confidential VA procurement information to potential contractors, which would give the contractors receiving those

⁴ VA OIG, [Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center Asheville, North Carolina](#), September 30, 2019; and VA OIG, [Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina](#), October 16, 2018.

details an unfair advantage in the procurement process.⁵ The allegations concerned a request for information VA issued in the fall of 2017 to obtain contracted support related to the VA STOP Fraud, Waste, and Abuse initiative. A VA office had developed criteria and ranked plans submitted by 37 respondents in response to the request for information. A former VA employee had allegedly obtained the rankings and approached two potential contractors to help them win the contract. The OIG sought testimony from the former VA employee, who declined to speak with OIG staff. The OIG ultimately determined there was insufficient evidence to substantiate the allegations. Had the OIG been able to compel the former employee's testimony, evidence might have been developed sufficient to support a criminal referral or to recommend administrative action to the Department.⁶

Example 3. Facility Leaders' Oversight and Quality Management Failures Related to a Surgeon's Poor Quality of Care

The OIG conducted an inspection in response to multiple allegations of a thoracic surgeon's poor quality of care.⁷ The facility director hired the surgeon in August 2013 although facility leaders knew of malpractice issues and the surgeon's prior relinquishment of a state medical license to avoid prosecution of a disciplinary case. Facility leaders subsequently were deficient in granting and continuing the surgeon's clinical privileges without required evidence of competency. The surgeon was removed in October 2017 without following required processes, including notifying external reporting agencies. As a result, facility leaders could not report the surgeon to the National Practitioner Data Bank and were delayed in reporting to state licensing boards. These failures led the OIG to review service file documentation for 50 other facility healthcare providers, which revealed deficiencies in facility oversight. The facility leaders at the time the surgeon's initial privileges and credentials were granted had left VA employment before they could be interviewed by the OIG and were, therefore, unavailable to detail their actions and decisions to OIG staff, depriving the OIG of insight into the hiring and clinical privileging oversight processes and limiting the OIG's ability to recommend improvements.

Example 4. Review of Improper Dental Infection Control Practices

The OIG determined that a dentist potentially exposed 592 veterans to blood-borne pathogens as a result of improper dental sterilization practices. In connection with the VA OIG's review of failed dental infection control practices, the OIG was unable to conduct a detailed interview of the dentist at the center of the allegations or to interview the supervisor (the chief of dental services) because both had left federal service when they became the focus of the review and then declined to be interviewed.⁸ The

⁵ VA OIG, [Alleged Improper Release of Procurement Information](#), May 1, 2019.

⁶ Testimonial subpoena authority under consideration in H.R. 2428 would not apply to criminal proceedings.

⁷ VA OIG, [Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi](#), August 28, 2019; VA OIG, [Inadequate Intensivist Coverage and Surgery Service Concerns, VA Gulf Coast Healthcare System Biloxi, Mississippi](#), March 29, 2018.

⁸ VA OIG, [Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VA Medical Center, Tomah, Wisconsin](#), September 7, 2017.

inability to compel testimony hampered the OIG's investigation. That limitation also curtailed review of the alleged safety issues and the ability to address a key objective of the inspection: to identify all factors that might have contributed to facility leaders being unaware of the dentist's improper sterilization practices. The inability to speak with them also prevented the OIG from fully examining how the dental clinic was supervised.

These examples demonstrate that the inability to subpoena individuals who are not current VA employees not only hampers our oversight work, it also limits the OIG's ability to identify and recommend improvements to processes, systems, and controls that can help prevent the recurrence of fraud, waste, and abuse in VA's operations.

OTHER LEGISLATION

The OIG has issued several reports that relate to other pieces of legislation being considered by the Subcommittee today, including reports on the VA Police Service, employee background investigations, and VA's inventory management and supply chain. Beyond helping VA improve its programs, operations, and services, the OIG work referenced below is meant to inform congressional oversight and legislation that prevents risks to veterans, their caregivers, and families.

Oversight of the VA Police Program

Our December 2018 report, *Inadequate Governance of the VA Police Program at Medical Facilities*, detailed the OIG's audit of the VA security and law enforcement program to determine whether there was an effective governance structure to ensure the program was meeting its objectives, including protecting individuals at VA medical facilities.⁹ The OIG also examined whether the police workforce met staffing requirements and whether there was an adequate inspection program of its police units. The OIG found that VA did not have adequate governance over its police program to ensure effective management and oversight. Problems stemmed from confusion about police program roles and authority as well as the lack of a coordinated and centralized governance structure. The OIG made five recommendations for clarifying oversight responsibilities and evaluating the need for a centralized management entity, ensuring facility-appropriate police staffing models are implemented, addressing facilities' staffing challenges, providing resources for timely inspections of police units, and developing procedures for investigating medical facility leaders' alleged misconduct.

H.R. 2429 includes language related to the OIG recommendation that staffing models be created. This recommendation remains open two years after the report was issued.

Employee Background Investigations

In a March 2021 management advisory memorandum on risks associated with expedited hiring in response to COVID-19, the OIG outlined issues uncovered in the course of a team's oversight work that

⁹ VA OIG, [Inadequate Governance of the VA Police Program at Medical Facilities](#), December 13, 2018.

were serious enough to merit prompt notification to VA.¹⁰ The issues were recognized due to the audit team's earlier report on the personnel suitability program.¹¹ The March 2021 and earlier work demonstrate persistent issues VA has faced in managing the personnel suitability program to ensure investigations are completed timely for medical facility staff.

Inventory Management and Supply Chain

The *VA Supply Chain Resiliency Act* requires the VA Secretary to provide a report to the House and Senate Veterans' Affairs Committees describing the items the Secretary considers critical to responding to the COVID-19 pandemic and future epidemics, pandemics, and emergency situations. The report must also contain the quantities of items identified in the report that are available at all VA facilities and emergency caches as of the date of enactment. Before the pandemic, multiple OIG reports found that some VA medical centers did not consistently have supplies when and where they were needed for patient care, and that some facilities faced long-standing barriers to real-time tracking of inventory, distribution, and storage. During the pandemic the OIG found that VA medical centers had to manually enter personal protective equipment inventory information into supply-tracking databases and tools.¹² Given the manual data entry issues, the OIG is concerned that the congressionally required report will include unreliable data. As part of this mandated report, VA should describe the accuracy of and degree of assurance it has in the available inventory levels and its projections of anticipated needs.

CONCLUSION

The OIG strongly supports H.R. 2428, the Strengthening Oversight for Veterans Act of 2021, and appreciates this Subcommittee's consideration of the OIG's views on this legislation. Obtaining testimonial subpoena authority would strengthen OIG staff's ability to conduct rigorous and thorough oversight of VA programs and operations, and to report meaningful findings that allow VA to hold individuals accountable for misconduct that puts veterans, other VA beneficiaries, and employees at risk. Chairman Pappas, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.

¹⁰ VA OIG, [Potential Risks Associated with Expedited Hiring in Response to COVID-19](#), March 11, 2021.

¹¹ VA OIG, [Audit of Personnel Suitability Program](#), March 26, 2018.

¹² VA OIG, [Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic](#), February 24, 2021.