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*BEFORE THE*
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES
*HEARING ON*
H.R. 5843 AND OTHER PENDING LEGISLATION
MARCH 10, 2020

Chairman Pappas, Ranking Member Bergman, and Subcommittee Members, thank you for giving the Department of Veterans Affairs (VA) Office of Inspector General (OIG) the opportunity to discuss H.R. 5843, which would strengthen the effectiveness of the OIG's oversight of VA programs and operations by providing OIG investigators and other oversight staff the ability to obtain relevant information from individuals who are not currently 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.

## H.R. 5843 ANALYSIS

The Strengthening Oversight for Veterans Act of 2020, H.R. 5843, would give the VA Inspector General the authority to require by subpoena the attendance and testimony of individuals as necessary to enable the OIG to perform 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 care and safety of, or the services provided to, veterans and their families. Testimonial subpoena authority strengthens the OIG's ability to gather information identifying fraud, waste, and abuse related to VA programs and activities, information that is critical to allowing VA to hold responsible individuals accountable.

Under present authorities, the OIG can obtain documents and other materials from VA and other federal agencies and can subpoena such records from non-federal 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 with potentially relevant information to provide testimony in support of OIG oversight activities. H.R. 5843 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 who do not have an employment or contractual relationship with VA.

This authority would entrust the VA OIG with the same tool 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 OIG recognizes the gravity of this authority and is committed to using it prudently and with appropriate oversight. This legislation contains 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 of its intent to issue a subpoena, giving the witness the opportunity to testify voluntarily. Second, it requires the OIG to notify the Attorney General before issuing a subpoena and gives the Attorney General up to 10 days to object if the subpoena may interfere with an ongoing investigation. The OIG must also endeavor to arrange the interview in a location convenient to the witness. Additionally, the OIG will report to Congress, in the OIG's mandated semiannual report, 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 comprehensive oversight efforts. The following are several examples of occasions on which OIG personnel have been unable to fully analyze potential wrongdoing because they were unable to interview essential participants as they left federal employment before or during the OIG review.

### Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center in Asheville, North Carolina.

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 in 2014.[3] The concerns were identified in

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[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] *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.

response to OIG work on the facility's deficient examination of the radiologist's credentials, the radiologist's provision of inadequate health care, and the facility's delayed evaluation of that care.[4]

The OIG reported in 2019 that when the radiologist began providing services in 2014 the chief of imaging, the radiologist's supervisor, conducted inadequate oversight. When the chief of imaging finally reviewed the radiologist's work, it was noted as "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, which was after the OIG initially identified the concerns. 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 resulting 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 perspective on the facility's oversight process and insight on how clinical failures went undetected.

### Alleged Improper Release of Procurement Information.

The OIG investigated allegations that current and former VA employees provided confidential VA procurement information to contractors, which would provide the contractors an advantage in the procurement process.[5] In the fall of 2017, VA issued a request for information as part of an acquisition process to obtain support related to the VA STOP Fraud, Waste, and Abuse (FWA) initiative. The VA Improper Payments Remediation and Oversight Office developed criteria and ranked plans submitted by 37 respondents to the request for information. A former VA employee allegedly obtained the rankings and approached two potential contractors. The former VA employee allegedly told them he could use his knowledge of VA to help them win contracts to support the STOP FWA initiative. The OIG sought testimony from the former VA employee, who declined to speak with OIG investigators. 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 may have been developed sufficient to support a criminal referral or to recommend administrative action to the Department.

### Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi.

The OIG conducted an inspection in response to multiple allegations of a thoracic surgeon's poor quality of care.[6] Before hiring the surgeon in August 2013, facility leaders knew of malpractice issues and the

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[4] *Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina*, October 16, 2018.

[5] *Alleged Improper Release of Procurement Information,* May 1, 2019.

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

surgeon's prior relinquishment of a state medical license to avoid prosecution of a disciplinary case. Still, the facility director hired the surgeon. 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 providers, which showed deficiencies in facility oversight responsibilities. 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.

### Review of Improper Dental Infection Control Practices and Administrative Action at the VA Medical Center in Tomah, Wisconsin.

In connection with the VA OIG's review of improper dental infection control practices, the OIG was unable to conduct a detailed interview of the central person identified in the allegation, a dentist, or interview that individual's supervisor, the chief of dental services, since both left federal service during the course of the review and declined voluntary interviews.[7] Their absence hampered the OIG's ability to fully investigate the alleged safety issues and 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. The OIG determined the dentist potentially exposed 592 veterans to blood-borne pathogens as a result of improper dental sterilization practices.

## CONCLUSION

The OIG strongly supports H.R. 5843, the Strengthening Oversight for Veterans Act of 2020, and appreciates this Subcommittee's consideration of the legislation. Obtaining testimonial subpoena authority would strengthen the OIG's ability to conduct rigorous and thorough oversight of VA programs and operations. Chairman Pappas, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.

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[7] *Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VA Medical Center, Tomah, Wisconsin*, September 7, 2017.