DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

March 22, 2021

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File No. DI-20-0740

Dear Mr. Kerner:

I am responding to your June 18, 2020, letter regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA), Veterans Health Administration, located at the Veterans Affairs Medical Center (VAMC) in White River Junction, Vermont, that employees engaged in gross mismanagement and committed a gross waste of funds by failing to timely and accurately invoice the Dartmouth-Hitchcock Medical Center and the Geisel School of Medicine at Dartmouth (collectively, "Dartmouth") for medical services provided by VA. Ms. [redacted], a former accounting technician, stated that the White River Junction VAMC maintains approximately 25 sharing agreements with Dartmouth in which VAMC medical personnel, whose salaries are paid by VA, provide medical, teaching, and research services to Dartmouth under the sharing agreements. Dartmouth is obligated to pay VA for the hours worked by the medical personnel.

The Office of Inspector General's (OIG) Office of Investigations conducted an investigation and the results of the investigation are in the enclosed report. OIG substantiated the allegation and found that facility personnel did not comply with VHA policy with respect to medical, teaching, and research services sold to Dartmouth. The OIG did not substantiate that Dartmouth owes VA approximately $1,100,000, or more, for the services provided by VA employees to Dartmouth. The OIG found that the facility's failures with respect to documenting and administering sharing agreements primarily resulted from a lack of effective oversight and internal controls designed to ensure compliance with the policy.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20001

February 9, 2021

MEMORANDUM

TO: Office of Special Counsel

FROM: Office of Inspector General, Department of Veterans Affairs

SUBJECT: Report of Investigation re OSC File No. DI-20-0740

Summary

The U.S. Office of Special Counsel (OSC) referred to VA for investigation a whistleblower disclosure alleging that the White River Junction, Vermont VA Medical Center (the facility) failed to timely or accurately invoice Dartmouth College in Hanover, New Hampshire, for services the facility sold to Dartmouth. The VA Office of the Inspector General (OIG) accepted the referral and investigated the following allegation and related issues.

- ***Allegation:*** Veterans Health Administration (VHA) employees failed to keep adequate records related to VA sharing agreements with Dartmouth and failed to invoice Dartmouth timely and accurately for services provided by VA Medical Center medical providers.[1]

The OIG substantiated this allegation and found that facility personnel did not comply with VHA policy with respect to medical, teaching, and research services sold to Dartmouth. Under applicable policy, VA may sell healthcare resources only if the proposed sharing arrangements are properly vetted, documented, and authorized, and VA will receive sufficient revenue to cover the full cost of the resources sold.[2] The OIG found that facility staff provided services to Dartmouth on numerous occasions without an approved, executed contract in place. In addition, the facility failed to ensure full cost recovery to VA, as required under the directive, because it

[1] Letter from the Honorable Henry J. Kerner, Special Counsel, to VA Secretary Robert Wilkie, June 18, 2020.

[2] VHA Directive 1660.01, *Health Care Resources Sharing Authority – Selling*, June 20, 2018.

did not invoice Dartmouth properly and timely for the services provided by VHA physicians and researchers.

The whistleblower also alleged that "according to the acquisition utilization specialist overseeing the contracts, Dartmouth owes VA approximately $1,100,000, or more, for the services provided by VA employees to Dartmouth."[3] The OIG did not substantiate this claim. This figure represents the acquisition utilization specialist's estimated value of all fiscal year (FY) 2020 sharing agreements and not the amount of uncollected debt. A review performed in July 2020 by a facility auditor determined that the facility had not yet invoiced Dartmouth for approximately $86,000 in services rendered in FY 2020 under documented sharing agreements.

In its investigation of the primary allegation, the OIG team also sought to determine the underlying factors that led to these policy violations. The OIG found that the facility's failures with respect to documenting and administering sharing agreements primarily resulted from a lack of effective oversight and internal controls designed to ensure compliance with the policy. The facility's associate director has led efforts to address deficiencies in the administration of the sharing program, but the OIG found that many of these problems remain.

[3] Letter from the Honorable Henry J. Kerner, Special Counsel, to VA Secretary Robert Wilkie, June 18, 2020.

Introduction

Pursuant to 5 U.S.C. § 1213(c), on June 18, 2020, OSC referred to VA for investigation a whistleblower disclosure concerning the alleged failure to properly invoice Dartmouth for services provided by facility employees.[4]

The whistleblower, a former accounting technician at the facility, alleged that the facility failed to keep adequate records related to sharing agreements with Dartmouth and failed to invoice timely and accurately for services provided by facility medical providers and researchers over the past five years. The whistleblower asserted that Dartmouth owes VA approximately $1.1 million or more for these services. The whistleblower raised these concerns with her supervisors and facility leaders and alleged they did not take appropriate remedial action. OSC referred the allegations to VA because it concluded that there was a substantial likelihood of gross mismanagement and gross waste of funds.

The Office of Inspector General (OIG) accepted the referral for investigation. Specifically, the OIG, Office of Special Reviews (OSR) investigated the following allegation:

- VHA employees failed to keep adequate records related to VA sharing agreements with Dartmouth and failed to invoice Dartmouth timely and accurately for services provided by VA Medical Center medical providers.

The OIG team also investigated the whistleblower's claim that these failures resulted in Dartmouth owing VA approximately $1,100,000, or more, for services provided by VA employees. The OIG investigators also probed the extent to which a lack of leadership oversight and internal controls contributed to the policy violations.

Background

Sharing Agreements

VA is expressly permitted by statute to enter into arrangements to provide healthcare resources (HCR) to third parties in exchange for payment.[5] These arrangements are termed "selling sharing agreements."[6] The statute provides that VA may sell HCR if it first "determines [the sale] to be in the best interest of the prevailing standards of the Department medical care program."[7]

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[4] Letter from the Honorable Henry J. Kerner, Special Counsel, to VA Secretary Robert Wilkie, June 18, 2020.

[5] 38 U.S.C. § 8153(b).

[6] VHA Directive 1660.01 § 3(h).

[7] 38 U.S.C. § 8153(a)(1).

Likewise, the directive instructs that selling may occur "only if the HCR is within the scope of VA's authority, is authorized by law, and VA will receive revenue sufficient to recover the full cost of such HCR."[8] No oral sharing agreements are permitted.[9] The Medical Sharing/Affiliate Office (MSO), a component of VHA's Procurement and Logistics Office, operates as VA's lead program office for sharing HCR and provides oversight, training, and technical guidance to VA medical facilities that have sharing programs.

VHA Directive 1660.01 requires facilities to follow a specific process for entering into a sharing agreement. Initially, the facility's director must establish a business team to prepare a concept proposal for review by the assigned contracting officer, the MSO, and VA's Office of General Counsel (OGC), which typically details the costs of the service that the facility intends to sell, as well as the permitted scope of the provider's services. As part of this proposal, the medical facility director must certify in writing, with concurrence by the Veterans Integrated Service Network (VISN) director, that, among other things, services to veterans will not be diminished by the proposed sale of HCR and that the "agreement is necessary to maintain an acceptable level and quality of service . . . or will result in improvement of services to Veterans."[10] After the MSO and OGC approve the proposal, the facility's contracting officer works with the sharing partner—in this case, Dartmouth—to draft the sharing agreement. The draft agreement must be reviewed and approved by the MSO and OGC before it can be executed by the facility.

The directors of individual medical centers are specifically assigned responsibility for compliance with VHA Directive 1660.01, including adhering to applicable law and policy with respect to establishing and managing sharing agreements and ensuring that staff involved in the selling process are appropriately trained.[11] The assigned contracting officer is VA's signatory on any sharing agreement and is required to monitor and administer sharing agreements with the assistance of Contracting Officer's Representatives (CORs).[12] Only the contracting officer has the actual authority and assigned responsibility under the directive to bind VA to the terms of a sharing agreement—neither the providers nor senior leaders nor even CORs are authorized to do so.[13] CORs, administrative staff within the same service as the researcher or physician whose services are being sold, are responsible for facilitating billing and direct communications with

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[8] VHA Directive 1660.01 § 4.

[9] Medical Sharing/Affiliate Office, *Affiliate Guide to Health-Care Resource Contracting*, January 2020, at 27.

[10] VHA Directive 1660.01 § 3(b); *see also* 38 U.S.C. § 8153(e). Medical facilities within VHA are organized into regionally managed networks, referred to as VISNs. Under the directive, medical facility directors also have to certify that the resources sold "are not, or would not be, used to their maximum effective capacity." VHA Directive 1660.01 § 3(b).

[11] VHA Directive 1660.01 § 5(f)(3).

[12] VHA Directive 1660.01 §§ 5(d), 5(f).

[13] VHA Directive 1660.01 § 5.

the sharing partner.[14] The facility's fiscal service also supports the sharing program by generating invoices and receiving and tracking payments. As part of year-end reporting, fiscal service certifies that sharing agreements are documented, billed, and collected in accordance with policy or explains any deviation from policy.

The White River Junction Facility's Leadership Structure

The White River Junction facility is led by an executive director. The individual currently serving in that role has served in a permanent capacity since approximately April 2019. Prior to assuming the executive director position, he served as facility chief of staff for approximately two years. The chief of staff and associate director both report to the executive director. These three individuals constitute the facility leaders with respect to sharing agreement policy and practice.[15]

The facility's current chief of staff has served in that position in a permanent capacity since November 2019 and was acting chief of staff for two roughly six-month periods in mid-2018 and mid-2019. The chief of staff is the senior medical officer at the facility and oversees all clinical programs and staff. Further, pursuant to facility policy established in April 2019, the chief of staff is assigned overall responsibility for the sharing program and review process.[16]

The facility's current associate director assumed this position in August 2018. The associate director oversees the facility's administrative departments, including fiscal and logistics services, and other administrative services provided at the facility, such as contracting. Contracting staff are not employed by the facility directly, however. They are employed by VA to serve VHA facilities and have a separate organizational hierarchy within VHA's Procurement & Logistics Office. The fiscal service is led by the facility's chief financial officer (CFO), who reports to the associate director. The chief of accounting and the facility's auditor report directly to the CFO.

The White River Junction Facility's Relationship with Dartmouth

The facility has been affiliated with Dartmouth since 1946. All permanent VA staff physicians at the facility qualify for faculty appointment to Dartmouth's medical school.

The executive director, associate director, and chief of staff each described the relationship between the facility and Dartmouth as close, noting that the two entities often work together to recruit capable staff in order to attract medical professionals to such a rural geographic location.

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[14] VHA Directive 1660.01 § 5(f)(6).

[15] The term "facility leaders," as used in this memorandum, refers to the facility's executive director, associate director, and chief of staff.

[16] White River Junction VA Medical Center Memorandum 90-19-32, *Sharing Agreement Advisory Subcommittee of the Administrative Executive Board (SAASA)*, April 2019.

The executive director testified that the "very high quality of medical staff here . . . really flows directly from that relationship with Dartmouth," and remarked, "If we didn't have that, we would almost certainly have a lesser medical staff."

Through selling sharing agreements, facility physicians teach courses at Dartmouth, researchers participate in Dartmouth-led research projects, and, as mentioned, the facility and Dartmouth jointly recruit providers for specialty positions. The facility's known selling sharing agreements with Dartmouth were projected to raise $1.1 million in revenue for VA in FY 2020.

Overview of Investigation

To investigate the whistleblower's allegations, the OIG team reviewed legal and policy standards applicable to sharing agreements, as well as relevant email communications and documents from approximately the start of FY 2019 to the end of FY 2020. These documents included copies of the agreements, tracking information related to the agreements, financial records, training materials, and records of pertinent facility meetings, such as agendas, minutes, and presentations.

In addition, the OIG team interviewed numerous witnesses. On July 16, 2020, OIG investigators interviewed the whistleblower. Between July 24, 2020, and January 11, 2020, the OIG interviewed 18 additional individuals at the facility, VISN, and VA Central Office who were involved in creating, negotiating, administering, and overseeing sharing agreements.

Discussion

Allegation: VHA employees failed to keep adequate records related to VA sharing agreements with Dartmouth and failed to invoice Dartmouth timely and accurately for services provided by the facility's physicians and researchers.

The OIG substantiated the allegation that facility staff failed to comply with VHA Directive 1660.01 with respect to obtaining proper approval for and documenting arrangements to sell medical, teaching, and research services to Dartmouth in exchange for payment. The OIG found that facility physicians and researchers provided services to Dartmouth without approved and executed sharing agreements in place, often through informal sharing arrangements that did not receive proper authorization or review, as required by VHA policy.

Additionally, the OIG substantiated the allegation that there were often significant delays in invoicing Dartmouth for services sold pursuant to these arrangements, which created a risk that the facility would not obtain full cost recovery for services sold as required by VHA Directive 1660.01. The OIG did not substantiate the whistleblower's claim that these delays resulted in

Dartmouth owing VA approximately $1.1 million, or more, for services provided by VA employees.

The facility entered into sharing arrangements with Dartmouth that were not properly vetted, approved, or documented and failed to submit invoices to Dartmouth for up to years at a time.

The OIG found that VA physicians and researchers provided services to Dartmouth without approved, executed sharing agreements in place. For example, in November 2018, a physician informed the COR for research that Dartmouth had not been invoiced for any of her teaching services for approximately two years, and subsequent review revealed that there was no sharing agreement in place for her teaching. In May 2019, the COR for health services indicated in an email that four physicians in her service were working at Dartmouth and "should be on a contract but aren't."

In another example, a VA doctor served as the associate director of Dartmouth's internal medicine residency program from October 2014 to September 2018, but her sharing agreement expired in 2015, and Dartmouth was never invoiced for her services for the next three years. When the facility's fiscal service and contracting staff first became aware of this arrangement in 2019, they attempted to address the issue by creating an invoice for those missing years via a delinquent obligation memorandum (delinquent memo).[17] While the contracting office was preparing an agreement to support this physician's future work, she left the position at Dartmouth, and another VA provider filled her place in Dartmouth's residency program, also without an agreement in place.

Similarly, a senior member of the facility's clinical staff taught classes at Dartmouth for years without a sharing agreement in place. At one point, while a contract was being negotiated, facility and Dartmouth staff informed the physician that he could not continue to work until an agreement was finalized. He did not comply with these instructions to stop work because he was "in the middle of a course" and could not "drop that responsibility in midstream."

The OIG found that the staff involved in the financial aspects of sharing agreements—fiscal service and CORs—often were not aware these agreements existed until Dartmouth staff requested that VA send a bill for services provided. Both administrative personnel and CORs testified that, at times, the first they would learn of a provider's selling arrangement was through an email from Dartmouth requesting an invoice. In some instances, billing had not occurred for several months or even an entire year. The facility's current CFO, who worked at VA Central

[17] A delinquent memo is a document that facility staff created to support invoicing Dartmouth when a provider sold services to the university without an agreement in place. It requires a description of the services provided and the reimbursement sought, and it must be signed by the associate and executive directors, among others.

Office for nine years before starting his current position at the facility, told OIG investigators that he had "never" seen this type of situation previously in which a debtor was asking to pay VA.

For example, in March 2019, the COR for medical service and Dartmouth personnel discussed by email the fact that several VA physicians were providing services at Dartmouth without sharing agreements in place. A Dartmouth staff member indicated that the school has "been asking the VA for more than two years to set up contracts for the three [providers] who still have no contract. I also have to beg to be invoiced so that the charges can hit our accounts before year end."

The invoicing failures also extended to sharing arrangements that were documented properly. A Dartmouth employee stated in a May 2019 email to fiscal service staff, "It has been my experience in the past three years working for this department that I have had to ask multiple times for an invoice even when a contract is in place." In mid-2020, Dartmouth again emailed the facility's fiscal service to request invoicing for several VA providers. The Dartmouth employee wrote that seven accounts had not been invoiced since September 2019 and one account had not been invoiced since July 2018.

These examples reflect violations of VHA policy. First, informal sharing arrangements, through which VA employees provided services to Dartmouth in exchange for a promise of payment, violated VHA Directive 1660.01, which mandates that facilities follow a prescribed process for the proposal, negotiation, and documentation of selling sharing agreements.[18] In addition, as the directive only permits designated contracting officers to negotiate the terms of and execute selling agreements, VA service providers and other staff were agreeing to these arrangements with Dartmouth without any actual authority to bind VA in violation of VHA policy.[19]

Second, the invoicing lapses and delays also constitute violations of VHA Directive 1660.01 and related guidance. The failure to seek payment from a sharing entity frustrates one of the primary policy goals of Directive 1660.01, which is to ensure that "VA will receive revenue sufficient to recover the full cost" of services sold.[20] To that end, the directive requires that facility directors

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[18] VHA Directive 1660.01 § 13.

[19] VHA Directive 1660.01 § 5(d) (indicating that only "duly appointed and authorized" contracting officers are responsible for executing selling sharing agreements "and otherwise taking all actions affecting the terms of such selling sharing agreements or the rights of VA or a sharing entity under the terms of such agreements"). In contrast, the VHA Directive states that, even though CORs are delegated some contracting-related duties, "*CORs shall not execute, modify, or cancel selling sharing agreements, take any action affecting the terms of a selling sharing agreement ... or otherwise bind the Federal government to take or not take some action.*" VHA Directive 1660.01 § 5(f)(6) (emphasis in original).

[20] VHA Directive 1660.01 § 4. In addition, the MSO has stated in its written guidance on HCR sharing that, with respect to selling agreements, "the Government must obtain the 'full cost' of the resources being sold." *Affiliate Guide*, 28.

specifically assign COR duties to particular individuals, and that these duties include facilitating billing.[21] Indeed, if, as in this matter, invoices are not submitted to the sharing entity for months or years after the services are provided, then VA would not have recovered its costs at or around the time they were incurred, and VA was therefore deprived of the use of that revenue for an extended time period. Moreover, these billing failures presented a significant risk that VA would not be able to recover the full cost of services provided.

The OIG did not substantiate that Dartmouth owed VA $1.1 million or more.

Although these billing delays presented a substantial impediment to full cost recovery, the OIG did not substantiate the whistleblower's claim that VA suffered $1.1 million or more in losses. The whistleblower did not independently arrive at this figure. She told OIG investigators that the facility's acquisition utilization specialist (AUS), an employee in logistics service who tracked the status of sharing agreements, had told her that the delinquent collections totaled $1.1 million. Based on the OIG's investigation, it appears that the whistleblower was mistaken regarding the nature of the AUS's estimate, as that figure represented the AUS's estimate in January 2020 of the total expected sharing arrangement revenue for FY 2020 – including approved agreements, proposed agreements, and informal arrangements that the AUS was aware of—and not the amount of uncollected revenue. The AUS did not estimate arrears or losses related to sharing agreements as part of his tracking efforts.

The OIG team did not identify any complete accounting of the status of billing and collections for all sharing arrangements during the period under review. In July 2020, after the whistleblower's departure from VA, the CFO tasked the fiscal service auditor with reviewing the sharing agreement accounts to determine invoicing status. The auditor created a document to track information about known sharing arrangements, costing, billing cycles, and prior invoicing. Using this data, the auditor calculated that, as of July 2020, VA had not yet billed Dartmouth for approximately $86,000 for services performed on approved, documented selling agreements in FY2020.[22]

Governance failures contributed to the policy violations at the facility, and efforts to reform the program have been inadequate.

The OIG also investigated the role of facility leaders, including the current executive director, chief of staff, and associate director, in the sharing program and found that compliance failures

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[21] VHA Directive 1660.01 § 5.

[22] OIG investigators followed up with the CFO in January 2021 to determine the status of billing and collections with respect to the amount identified by the auditor in July 2020. The CFO indicated that Dartmouth has been billed "significantly more" than this amount since this analysis was completed and that finance "has billed for everything for which [they] have complete information."

stemmed from a lack of oversight and internal controls related to sharing policy. The associate director has spearheaded recent efforts to reform the sharing program, but those efforts have not been fully successful to date in remediating the deficiencies.

Facility leaders failed to exercise sufficient oversight and adopt effective internal controls.

VHA Directive 1660.01 specifically assigns responsibility for overseeing compliance with VA's sharing program policies to the medical facility director, including ensuring that staff involved in the sharing program are adequately trained.[23] In addition, the facility's current policies task the chief of staff and associate director with oversight responsibilities in this area.[24] Facility leaders are also generally responsible for creating and maintaining an effective system of internal controls. An internal control is a policy, procedure, or process that an entity implements to provide reasonable assurance that the entity's objectives will be achieved and to ensure compliance with applicable law and policy.[25] Internal controls grow from an iterative assessment of the risks an entity faces in achieving its goals, what tolerance it has for the existence of those risks, and what measures can be put in place to mitigate them. Facility leaders failed to institute adequate training, systems, and other internal controls in order to ensure compliance with VHA policies.

Sharing with Dartmouth was encouraged by facility leaders as a means to attract high-quality providers and researchers to the facility. Facility and VISN leaders testified that highly qualified applicants would be less likely to accept positions at a rural facility like the White River Junction VA Medical Center without the opportunity to work at Dartmouth. While it was not improper to entice recruits with the prospect of academic or research work, facility leaders failed to ensure that physicians and researchers understood VHA policy with respect to sharing arrangements, and, in particular, that they lacked legal authority to provide any services to Dartmouth absent an approved, executed sharing agreement.

Facility leaders recognized this risk and stated that they warned potential hires that working for Dartmouth was a possibility and not a guarantee but acknowledged that they provided no training to physicians or researchers regarding compliance with VHA policy. The executive director testified that, in light of the joint recruiting, "there's always a danger" that physicians speaking with him about prospective sharing arrangements "are going to leave a conversation with me with a belief that's different than what I had intended them to leave with," i.e., that they had his

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[23] VHA Directive 1660.01 § 5(f).

[24] Memorandum 90-19-32 ¶ 5(a).

[25] VA Financial Policy, Volume I, Chapter 5, *Management's Responsibility for Internal Controls*, February 2019.; OMB Circular No. A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, July 2016.

approval to go forward. The chief of staff conceded that "there's not a good understanding by the clinical staff of the—sort of all this legal part of this" and that further education was needed so that physicians have "clear understanding" as to "what has to be in place before they are allowed to either teach or work." A contracting official who works with the facility shared this view and stated, "I think we got the sense that there was just kind of this, well, I'll just go over and it'll be covered somehow." The facility's former CFO echoed this view, testifying that some facility providers "[did not] understand the importance" of the contracting process because it was an administrative, not medical, requirement.

In addition, facility leaders failed to institute adequate controls in order to ensure that they promptly identified situations in which services were being provided without a proper agreement in place, as evidenced by the fact that these informal arrangements continued to occur throughout the time period under review, and facility staff typically learned about these arrangements only because of requests for invoices from Dartmouth staff. Facility leaders also failed to institute any consequences for policy violations, such as training or additional oversight, and witnesses informed the OIG investigators that they knew of no repercussions for providers who entered into such informal arrangements without the requisite approvals. The associate director agreed that medical sharing issues "did not rise to the top" and were given insufficient attention.[26] The facility's former CFO noted that while leadership previously considered instituting controls such as tying a provider's performance pay to policy compliance, or requiring yearly attestations of policy compliance from each provider, no such controls were implemented.

In addition to failures with respect to training and oversight of clinical research staff, the OIG found that there were no systems or controls in place to ensure that administrative staff properly maintained records and completed invoicing in a timely manner. CORs lacked formal systems or processes to track information concerning the sharing agreements they managed and received no training on day-to-day contract administration. Similarly, the fiscal service failed to keep adequate records—including copies of all the current selling sharing agreements or a system of tracking what contracts had been invoiced and for what periods—in order to know that some sharing agreement accounts were years behind in billing. Billing records related to sharing agreement accounts provided no method for easily discerning what periods of time or amounts had been billed in the past. As a result, fiscal service staff sometimes had to reach out to Dartmouth personnel to determine billing status.

The facility also lacked appropriate controls limiting the practice of invoicing via delinquent memo. The facility's former CFO, who retired in December 2018, regularly deployed delinquent memos to justify an invoice for provider services sold without an executed agreement.

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[26] The executive director and chief of staff attributed part of their failings in oversight to the knowledge vacuum and attention deficit created by a "tremendous" amount of turnover at the facility in recent years, prior to their tenures.

Delinquent memos were prepared by CORs and described the work done and the amount to be collected.

Commonplace use of delinquent memos for invoicing exacerbated the sharing program's problems because it provided an avenue for the facility to seek reimbursement while circumventing the contracting requirements established by statute and VHA Directive 1660.01. As required signatories on every delinquent memo, the associate and executive directors were aware of this common practice but did not curtail it. The CFO testified that invoicing via delinquent memo was appropriate in situations when there was not adequate time to put an agreement in place and the services had to be provided "right this second." When asked whether delinquent memos should be used for situations other than those involving urgent patient care, he conceded that they "shouldn't happen." When asked by OIG investigators, neither the chief of accounting, the former associate fiscal officer, the CFO, the former CFO, the associate director, nor the executive director could identify any written policy that supported the use of delinquent memos in this context.

Facility leaders' efforts to improve the sharing program have not been sufficient.

The associate director has spearheaded efforts in the last two years to improve the integrity of the facility's sharing program. Beginning in mid-2018, the AUS began to operate as a "super COR" to support the CORs in their functions and act as a liaison between CORs, physicians, contracting, fiscal, and other stakeholders in the sharing program.

In mid-2019, the facility re-instituted the Sharing Agreement Advisory Subcommittee of the Administrative Executive Board (SAASA), which meets monthly.[27] SAASA includes stakeholders from logistics, contracting and fiscal services, as well as clinical staff, to discuss issues relating to the sharing program. The chief of staff chairs SAASA meetings. The associate director and others have also participated in regular meetings with their Dartmouth counterparts to discuss and make improvements to the sharing program.

In January 2020, a single contracting officer, Contract Specialist 1, began managing all sharing agreements at the facility. In mid-2020, the CFO assigned the fiscal service auditor the ongoing responsibility to work with an accounting technician to improve sharing agreement invoicing. According to facility staff, these efforts have resulted in improvements to sharing program administration, such as fewer providers selling services to Dartmouth without an agreement in place.

Despite these improvements, the testimony of facility staff, as well as recent documentary evidence, reflects that problems persist. Some providers continue to work without agreements in

[27] Memorandum 90-19-32. According to the facility's former CFO, this committee previously existed from approximately 2013 to 2017.

place, and some staff, including CORs and physicians, do not understand their roles and responsibilities in the sharing process. Furthermore, invoicing is still not always timely. The AUS stated in a January 2020 email, for example, that problems continued to arise from "providers performing services without approved agreements ever being in place," and "for the approved agreements we do have, very little, if at all, billing and invoicing . . . being performed."

The SAASA provides an avenue for communication between stakeholders in the various services that are involved in sharing agreements, but it has failed to adequately demand or enforce any accountability with respect to compliance with VHA and facility policy from relevant staff. The intended purpose of the committee is to bring together CORs, administrators, and clinical staff to address problems and collaborate on solutions, but the facility's chief supply chain officer, who regularly attended SAASA meetings, opined that the SAASA has not been very productive because it amounts to no more than a briefing about medical sharing. The chief of staff told OIG investigators that, in terms of overseeing the sharing program as SAASA chair, "looking over the numbers or accounting for hours . . . is not something that I've done yet."

The former associate fiscal officer recognized as late as mid-2020 that billing on sharing agreements "was kind of all over the place," leading fiscal service to team up the auditor and accounting technician to improve invoicing. The chief of accounting estimated 20 percent of the sharing agreement invoices produced today are still supported using delinquent memos. The CFO likewise told the OIG that while things have improved since he took his post, "they are not where [he] want[s] them."

Finally, the executive director lacks engagement in the sharing program. He admitted to OIG investigators that he is not involved in the SAASA and does not receive regular briefings about the sharing program. Before taking on his current role in April 2019, the executive director had been the permanent chief of staff since July 2017 and oversaw the clinical staff during much of the period under review. However, as the associate director told the OIG, the executive director today is "not super involved in any of this." VHA Directive 1660.01 specifically assigns responsibility to medical center directors for overall compliance with sharing program policies, which is logical given that medical sharing programs require collaboration across the services that report up to the director, including clinical staff, fiscal staff, and logistics personnel, as well as contracting representatives.[28]

Conclusion

The OIG substantiated the whistleblower's allegation regarding recordkeeping failures with respect to the facility's sharing program, finding that facility personnel failed to comply with VHA policy by providing medical, teaching, and research services to Dartmouth without first

[28] VHA Directive 1660.01 § 5(f).

obtaining approved, executed selling agreements. In addition, the OIG substantiated the allegation that facility staff did not properly and timely invoice Dartmouth for services rendered by VA employees pursuant to these arrangements. The OIG found that the facility failed to submit invoices to Dartmouth under multiple sharing agreements for periods ranging from a few months to several years, which compromised VA's ability to recover the full cost of services provided, as required by VHA policy.

The OIG did not substantiate the allegation that Dartmouth owes VA $1.1 million or more, however. Based on the OIG's investigation, it appears that the whistleblower mistakenly believed that this amount represented uncollected revenue, but, instead, it was an estimate of projected revenue for all FY 2020 sharing arrangements known to the AUS. The only recent analysis that the OIG team identified related to the status of billing was performed by the facility's auditor in July 2020. It was primarily aimed at determining the status of FY 2020 invoices and identified approximately $86,000 in unbilled services provided pursuant to sharing agreements.

The OIG also assessed the role of facility leaders in the sharing program failures. The OIG found that several interconnected issues contributed to this noncompliance, including facility leaders' lack of oversight with respect to facility physicians and researchers who provided services to Dartmouth, as well as administrative staff who handled the administrative aspects of such arrangements. In addition, facility leaders failed to institute effective internal controls to ensure compliance with VHA policy. The OIG found that, during the period under review, facility leaders largely tolerated practices that were not compliant with VHA selling agreement policies, although one director began to take steps to promote better practices. These efforts to reform the sharing program have resulted in improvements, but informal sharing arrangements and billing delays continue to present compliance challenges.

DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20001

February 9, 2021

MEMORANDUM

TO: Office of Special Counsel

FROM: Office of Inspector General, Department of Veterans Affairs

SUBJECT: Addendum to Report of Investigation re OSC File No. DI-20-0740

List of Interviewees

Name	Title	Station
[redacted]	Accounting Technician (former), White River Junction VAMC (**Whistleblower**)	White River Junction, VT
[redacted]	Health Services Specialist/Contracting Officer's Representative (COR), Medical Services Service, White River Junction VAMC (COR 1)	White River Junction, VT
[redacted]	Budget Analyst/COR, Research Service, White River Junction VAMC (COR 2)	White River Junction, VT
[redacted]	Administrative Officer/COR, Primary Care Service, White River Junction VAMC (COR 3)	White River Junction, VT
[redacted]	Auditor, Fiscal Service, White River Junction VAMC	White River Junction, VT
[redacted]	Chief Supply Chain Officer, Logistics Service, White River Junction VAMC	White River Junction, VT
[redacted]	Chief of Accounting, Fiscal Service, White River Junction VAMC	White River Junction, VT
[redacted]	Financial Quality Assurance Team Manager, VISN 1 (former Associate Fiscal Officer, White River Junction VAMC)	White River Junction, VT
[redacted]	Chief Financial Officer, White River Junction VAMC	White River Junction, VT

[redacted]	Contract Specialist, VHA Network Contracting Office 1 (Contract Specialist 1)	Togus, ME
[redacted]	Contract Specialist, VHA Network Contracting Office 1 (Contract Specialist 2)	White River Junction, VT
[redacted]	Chief, Research Service, White River Junction VAMC	White River Junction, VT
[redacted]	Chief of Staff, White River Junction VAMC	White River Junction, VT
[redacted]	Executive Director, White River Junction VAMC	White River Junction, VT
[redacted]	Associate Director, White River Junction VAMC	White River Junction, VT
[redacted]	Director, Medical Sharing/Affiliate Office	Dallas-Fort Worth, TX
[redacted]	Network Director, VISN 1	Augusta, ME
[redacted]	Acquisition Utilization Specialist, White River Junction VAMC	White River Junction, VT
[redacted]	former Chief Financial Officer, White River Junction VAMC	White River Junction, VT

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20001

September 17, 2024

MEMORANDUM

TO: Office of Special Counsel

FROM: Office of Inspector General, Department of Veterans Affairs

SUBJECT: Supplement to Report of Investigation re OSC File No. DI-20-0740

On June 18, 2020, the U.S. Office of Special Counsel (OSC) referred to VA for investigation a whistleblower disclosure alleging that the White River Junction VA Medical Center in White River Junction, Vermont (the facility), failed to timely or accurately invoice Dartmouth College in Hanover, New Hampshire (Dartmouth), for services the facility sold to Dartmouth for at least five years. The VA Office of the Inspector General (OIG) accepted the referral and investigated the allegation and related issues.

The OIG submitted its report of investigation to OSC on February 9, 2021. On February 29, 2024, OSC contacted VA with questions about the extent of unbilled services prior to fiscal year (FY) 2020 and subsequent corrective or disciplinary actions. The OIG responded to those questions on March 22, 2024, noting that during its 2020–2021 investigation it did not ascertain the total amount of losses due to unbilled sharing arrangements or number of impacted staff during the review period. OSC replied with a request for a supplemental report addressing the entire five-year period referenced in the allegation to the extent possible. Following further discussions between OIG and OSC staff, on July 25, 2024, OSC amended its February 2024 request to only seek information concerning the scope of the OIG's 2020–2021 investigation and limitations that the available evidence placed on the OIG's ability to make findings, as well as for OIG to make a follow-up inquiry to the facility to learn of any disciplinary or corrective actions taken subsequent to the OIG report. The OIG submits the supplemental information in this letter to address these issues. As detailed further below, the OIG substantiated the whistleblower's allegation. However, despite the OIG's best efforts to quantify the full extent of

losses or affected providers through its investigation, limitations in the available evidence prevented the OIG from reaching findings on these issues.

The OIG's 2020–2021 investigation included reviewing emails, documents, and testimony that covered events and conduct extending beyond the five-year period referenced in the whistleblower's allegation. First, the OIG requested and received documents from witnesses, including copies of sharing agreements, documents tracking information related to the agreements, financial records, and records of relevant meetings. For example, a contracting official assigned to the facility provided copies of all sharing agreements, both active and inactive, that the facility had on record as of the date of the document request in August 2020. These records included contracting documents for performance periods dating back to October 2015. Similarly, the OIG obtained the document used by the facility's acquisition utilization specialist to track the status of sharing agreements, including approved agreements, proposed agreements, and informal arrangements known to the specialist. This document included information on sharing arrangements with performance periods dating back to July 2015. Second, the OIG interviewed numerous witnesses who were involved in creating and overseeing sharing agreements at the facility, including witnesses with knowledge of events covering more than the five-year period described in the allegation. Finally, the OIG collected emails for relevant custodians dated on or after April 1, 2019, the month the whistleblower began employment at the facility, and through mid-2020. Email threads gathered out of this time frame included messages older than April 2019.[1] As indicated in the report of investigation, the OIG learned from documents, witnesses, and emails about undocumented or unbilled sharing arrangements dating back to at least October 2014. Consequently, the OIG's investigation covered relevant conduct encompassing the entire five-year period referenced by the whistleblower.

The evidence the OIG obtained was sufficient to substantiate the whistleblower's allegation that VA employees failed to invoice Dartmouth timely and accurately for services provided by VA facility medical providers for at least five years.[2] During its investigation, the OIG further sought to determine the extent of unbilled or undocumented sharing arrangements and the potential monetary losses to VA occasioned by them.[3] However, the evidence available was not adequate

[1] The OIG determined that collecting emails for the entire five-year period referenced in the allegation would not materially advance the investigation and would have unduly delayed completing the investigation.

[2] The OIG did not substantiate the whistleblower's additional allegation that Dartmouth owed VA $1.1 million or more for sharing arrangements. The whistleblower based this allegation only on the acquisition utilization specialist's finding that the total value of all FY 2020 sharing arrangements between Dartmouth and the facility was $1.1 million. As noted above, the specialist's tracking did not reflect either revenue collected under the agreements or uncollected revenue. Thus, the whistleblower appears to have misunderstood the import of the $1.1 million figure she learned from the specialist.

[3] According to the facility's fiscal auditor, the $86,000 in unbilled services described in the OIG's report of investigation pertained only to FY 2020. This auditor tried to ascertain billing status for all outstanding sharing arrangements as of July 2020, and his research document referenced records which extended for some providers as

to reach findings on those issues. The OIG found that records related to informal or unbilled sharing arrangements were incomplete because these undocumented arrangements, by their nature, produce few or no records. Further, shared services were sometimes paid for long after they were rendered, making it difficult, or even impossible, to determine the loss occasioned by the failure of or delay in payment. The OIG found that, due to gaps in documentation, interviews with facility staff were generally the most probative evidence concerning undocumented sharing arrangements, particularly for those arrangements that were several years old by the time of the investigation. Yet, even at the time of these interviews in 2020 and 2021, witnesses could not recall all relevant events in detail. Consequently, the OIG reached a finding as to the whistleblower's allegation but was unable to further quantify the impact or losses.[4]

Finally, in response to OSC's question, the OIG contacted the facility's executive director in July 2024 to request an update on any corrective or disciplinary actions taken to address its findings after the report was issued in February 2021. On August 9, 2024, the executive director replied,

> In late 2022, the Chief of Staff, with support from the Office of Clinical Operations, began an effort to regularly review and update clinician labor mapping. As of today, services are scheduled to meet with the Chief of Staff quarterly to review various metrics including Labor Mapping, to ensure time is appropriately allocated.
>
> Starting in February 2024, the [facility] Medical Sharing Agreement Advisory Subcommittee created and implemented a standardized template to ensure a consistent review of our sharing agreements occur, reviewing need and appropriateness.
>
> No disciplinary actions were taken.

The OIG appreciates the opportunity to respond to OSC's inquiry in this matter.

far back as FY 2017. As noted above, the facility's acquisition utilization specialist tracked the status of sharing arrangements but did not track uncollected revenue or potential losses related to them.

[4] Because data limitations led the OIG to rely heavily on witness interviews during its investigation, it is unlikely that renewed efforts to investigate the allegations over three years later would uncover additional probative evidence.