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Washington, D.C. 20036-4505

The Special Counsel

May 8, 2025

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-20-000740

Dear Mr. President:

I am forwarding to you reports transmitted by the Department of Veterans Affairs (VA) to the Office of Special Counsel (OSC) in response to the Special Counsel's referral of disclosures of wrongdoing at the Veterans Health Administration (VHA), VA Medical Center (VAMC) in White River Junction, Vermont. OSC has reviewed the disclosures, agency reports, and whistleblower comments, and, in accordance with 5 U.S.C. § 1213(e), I have determined that the reports contain the information required by statute and the findings appear reasonable.[1] The following is a summary of the allegations, findings, and whistleblower comments.

The whistleblower, [redacted], a former accounting technician who consented to the release of her name, disclosed that VA officials engaged in conduct that constituted gross mismanagement and a gross waste of funds. Specifically, the whistleblower alleged that the White River Junction VAMC failed to timely or accurately invoice the Dartmouth-Hitchcock Medical Center and the Geisel School of Medicine at Dartmouth (collectively, "Dartmouth") for medical services provided by the VA for at least five years. The whistleblower stated that the VAMC maintained about 25 sharing agreements, which obligated Dartmouth to pay the VA for hours worked by VA medical personnel who provided medical, teaching, and research services to Dartmouth, but failed to keep adequate records of the agreements. The whistleblower alleged that, according to the acquisition utilization specialist (AUS) overseeing the contracts, Dartmouth owed the VA approximately $1,100,000, or more, for services provided by VA staff.

[1] The whistleblower's allegations were referred to former VA Secretary Robert Wilkie. The VA Office of Inspector General (OIG), Office of Investigations, conducted the investigation.

The agency investigation partially substantiated the whistleblower's allegations, finding that the White River Junction VAMC failed to invoice Dartmouth timely and accurately for services provided by VA medical staff for at least five years. Specifically, the investigation found that the facility: (1) did not comply with VHA Directive 1660.01 by failing to have a prescribed process for the proposal, negotiation, and documentation of selling sharing agreements and by failing to properly approve and execute these agreements with Dartmouth, noting that facility staff provided services without having agreements in place; (2) failed to ensure full cost recovery to the VA, per VHA Directive 1660.01 and 38 U.S.C. § 8153, by not invoicing Dartmouth for up to three years at a time, depriving the VA of the use of that revenue; and (3) failed to properly document and administer the sharing agreements primarily due to a lack of effective oversight and internal controls designed to ensure compliance with policy.[2]

The agency investigation did not substantiate the allegation that Dartmouth owed the VA approximately $1,100,000, or more, for provided services. The investigation found that the AUS's estimated value of $1,100,000 represented the estimated value of all fiscal year (FY) 2020 sharing agreements and not the amount of uncollected debt. Relying on a review performed by a facility auditor in July 2020, the report noted that the facility had not yet invoiced Dartmouth for approximately $86,000 in services rendered in FY 2020 on approved and documented selling agreements. As of January 2021, the facility's Chief Financial Officer (CFO) indicated the VA had billed Dartmouth for all services for which they had complete information.

OSC asked the agency for a supplemental report to learn the extent of unbilled services provided by VA staff to Dartmouth prior to FY 2020. The OIG stated that due to the limitations in the available evidence, it was unable to quantify the full extent of losses or affected providers. Yet, the OIG indicated that it learned from documents, witnesses, and emails about undocumented or unbilled sharing arrangements dating back to at least October 2014.

The report noted that the White River Junction VAMC made prior efforts to improve the sharing program but that these efforts have not been sufficient. For example, beginning in mid-2018, the VAMC's AUS began to operate as a "super" COR to support CORs in their functions and act as a liaison between CORs, physicians, contracting and fiscal services, 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 includes various stakeholders to discuss issues relating to the sharing program; in January 2020,

[2] The investigation found leadership failed to institute internal controls (i.e. adequate training of physicians and researchers on VHA policy related to sharing arrangements; training of contracting officer's representatives (CORs) on day-to-day contract administration; and prompt identification and response to instances of non-compliance, including consequences for policy violations) and systems for staff to track sharing agreements, maintain records, and complete timely invoicing, opting instead to use delinquent memos for invoicing, exacerbating the problem.

a single contracting officer began managing all sharing agreements at the facility; and in mid-2020, the facility's CFO assigned to the Fiscal Service Auditor the ongoing responsibility of working with an accounting technician to improve sharing agreement invoicing.

In a supplemental request, OSC asked what action the VA had taken or planned as a result of the investigation, as required under 5 U.S.C. § 1213(d)(5). The VA stated that the facility's Chief of Staff, with the Office of Clinical Operations' support, began an effort in late 2022 to regularly review and update clinician labor mapping.[3] The VAMC's specialty services are scheduled to meet with the Chief of Staff quarterly to review various metrics, including labor mapping. Also, in February 2024, the SAASA created and implemented a standardized template to ensure consistent reviews of sharing agreements.

In the comments, the whistleblower highlighted that the $86,000 in services the facility provided to Dartmouth in FY 2020 only represented documented sharing agreements and that the facility provided services for years without approved and signed agreements. She stated that the estimated amounts owed by Dartmouth for FY 2020 and prior fiscal years would be difficult to determine since there were VA employees providing services that were unknown to the Contract Specialist and the AUS. She stated that, for all known sharing agreements, an external audit should be completed to ensure that an auditor, who does not report to facility leadership, uncovers all issues related to the Dartmouth sharing program and conducts a complete accounting of all billing transactions. The whistleblower further stated that she raised her concerns with the sharing agreements to leadership, but they ignored her concerns and are, therefore, part of the sharing program's systemic failure to comply with VHA policy.

While the agency has initiated corrective measures, I am concerned that the White River Junction VAMC's efforts to improve the sharing program continue to be insufficient. It is not clear that the facility has a prescribed process for the proposal, negotiation, and documentation of sharing agreements, or that there are sufficient internal controls, such as training of physicians and researchers, as well as CORs. There is also no known process by which the facility may promptly identify and respond to instances of non-compliance, including consequences for policy violations, or a system for staff to properly track sharing agreements, maintain records, and complete invoicing in a timely manner. Accordingly, I urge the VA to take any additional action that responds to the investigation's findings and ensures compliance with policy. I thank the whistleblower for bringing these important allegations to OSC's attention.

As required by 5 U.S.C. § 1213(e)(3), OSC has sent copies of the agency reports, this letter, and the whistleblower's comments to the Chairmen and Ranking Members of the Senate

[3] Labor mapping is a process of assigning labor resources to the work areas where they belong. Labor hours are mapped to the areas where the employees work and are paid.

and House Committees on Veterans' Affairs. OSC has also filed redacted copies of these documents and the referral letter in our public file, https://osc.gov/. This matter is now closed.

Respectfully,

Charles N. Baldis
Senior Counsel and Designee
of Acting Special Counsel Jamieson Greer

Enclosures