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The Special Counsel

July 1, 2014

The Honorable Sloan D. Gibson
Acting Secretary
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Re: OSC File Nos. DI-14-3461 and DI-14-3589

Dear Acting Secretary Gibson:

Pursuant to my responsibilities as Special Counsel, I am sending to you a whistleblower disclosure that officials at the Department of Veterans Affairs (VA), Beckley VA Medical Center (Beckley VAMC), Beckley, West Virginia, engaged in conduct that may constitute a violation of law, rule, or regulation, gross mismanagement, an abuse of authority and a substantial and specific danger to public health.

[redacted] (the whistleblowers), program support assistants and enrollment advisors, consented to the release of their names. They disclosed that Beckley VAMC does not follow proper scheduling protocols; management concealed the size of patient waiting lists in advance of an audit; and administrators have seriously mismanaged the enrollment process. The allegations to be investigated are as follows:

- Scheduling staff were improperly directed to "zero out" patient wait times, in violation of agency policy;

- In advance of the May 2014 Access Audit, Beckley VAMC management improperly removed veterans from the New Enrollee Appointment Request (NEAR) list; and

- Enrollments staff has mismanaged the eligibility determination process, wrongly rejecting over 1,000 veterans, and causing excessive pending lists and wait times.

OSC has recently referred similar allegations of improper scheduling practices used to conceal unacceptable patient wait times at five other VA facilities. These matters are OSC File Nos. DI-13-4425, DI-14-2520, DI-14-0558, DI-14-2763, DI-14-2762, DI-14-3235, and DI-14-3424. The number of these referrals indicates that this is a systemic and pervasive problem at the VA. It also represents a serious threat to the safety and

well-being of veterans. In addition to these referred allegations concerning scheduling, OSC currently has over 60 pending cases alleging threats to patient health or safety at VA facilities, representing over a quarter of all cases referred by OSC for investigation government-wide.

Management Violated VA Scheduling Directives

[redacted] has worked at the Beckley VAMC since [redacted] in the Rural Health Initiative, which is a VA program designed to increase health care availability for rural veterans. As an enrollment advisor, [redacted] assists veterans in applying for health care benefits and works to schedule appointments once patients are enrolled. He alleges that during training by Beckley VAMC administrators lead clerks and supervisors verbally directed medical support assistants (MSAs) in clinics by to ensure that there were zero days between a patient's desired appointment date and the actual scheduled appointment date. [redacted] noted that these directions originated from [redacted]

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), para. 4.c.(4)(b)3 states that the patient must define the desired date for a return appointment. [redacted] explained that the desired date must be recorded in VistA, the VHA's electronic tracking system. Per the Directive, once the desired date is set in the system, even if that date is unavailable, it may not be altered to reflect the date of an appointment the patient accepts. [redacted] alleges that MSAs in Beckley VAMC clinics are instructed to record the patient's appointment as both the desired date and the accepted date. This is done to avoid showing that patients were frequently not scheduled on their desired dates. MSAs were directed to enter VistaA to check the patient's desired date. If that date was unavailable, they were instructed to exit out of the scheduling system, then enter back in, navigate to the date of the first available appointment, and use that date as both the desired date and appointment date. As a result, the system shows that the patient has no wait between the desired date and the date of the actual appointment.

[redacted] observed that this improper practice may be the unintended result of an agency-wide bonus system to ensure patients are seen within two weeks of their desired appointment date. The 14-day wait time limit is identified in agency training manuals as a performance measure. These inappropriate scheduling practices result in flawed wait time data and may have a direct adverse effect on patient health. Because there is no accurate data trail to track scheduling delays, it is impossible to identify patients who require time-sensitive follow-up appointments but who do not receive them.

Patients Were Wrongly Removed from the NEAR List

[redacted] alleged when the May 2014 Access Audit was announced, Beckley VAMC management improperly directed schedulers to remove patients from the NEAR

List. This list is a tool used by enrollment staff to communicate to primary care schedulers that a newly enrolled patient requested an appointment during the enrollment process. Pursuant to agency policy, primary care schedulers are responsible for making an appointment and removing the individual from the waiting list. *See* VHA Directive 2010-027.

[redacted] contends that in advance of the May 2014 Access Audit, [redacted] verbally directed schedulers to remove approximately 120 patients from the list. [redacted] alleges that some of these individuals waited years for appointments. [redacted] instructed schedulers to call waiting patients twice. If they did not respond, schedulers cancelled their requests and removed them from the NEAR list. If a veteran replied to a message or answered the phone, [redacted] directed schedulers to give them a randomly selected appointment slot, without asking the patient's preference, in violation of VHA Directive 2010-027. [redacted] explained that by using these improper methods, the NEAR list was reduced to 60 patients in advance of the Access Audit.

Mismanagement of the Eligibility Determination Process

[redacted] has been employed at Beckley VAMC since [redacted] and has worked in the Rural Health Initiative since 2012. [redacted] contend that the eligibility determination process at Beckley VAMC is chronically and seriously mismanaged. The whistleblowers explained that four issues cause serious delays in providing care to veterans, including: computer errors, improper management directions, lack of training, and lack of enrollment notification.

For VA healthcare eligibility, veterans must first apply for veterans health benefits in a process referred to as "enrollment." Veterans fill out enrollment applications detailing their service history, associated disabilities, and relevant financial information. This information ultimately determines whether applicants are eligible for VA healthcare. These forms are submitted online, over the phone, through the mail, or in person. The VA targets five to seven days to reach enrollment decisions and inform applicants regarding their eligibility.

The whistleblowers explained that Beckley VAMC staff take these applications and enter data into VistA, an integrated electronic health information management platform. VistA reviews enrollment data and makes preliminary eligibility determinations. Beckley VAMC staff must review these preliminary eligibility determinations to determine if VistA correctly classified the applicant, because recently updated classification criteria and unique individual circumstances often result in incorrect preliminary decisions. Employees must place alerts and explanatory comments on incorrect assessments.

All preliminary enrollment determinations in VA medical centers are sent to the VA Health Eligibility Center (HEC) in Atlanta, Georgia, for final processing. VistA is designed to automatically transfer these data daily, after the close of business, from

Beckley VAMC to the HEC. Staff in the HEC review alerts and comments indicating incorrect preliminary decisions. Unlike Beckley VAMC staff, HEC reviewers can override VistA's initial eligibility determination. However, [redacted] contends that if a file has no alert, HEC does not independently review it. When eligibility determinations are finalized, HEC is responsible for notifying veterans by letter of their enrollment status and appeal rights. *See* VHA Handbook 1601A.03. In order to expedite access to care, Beckley VAMC enrollment staff can also notify eligible veterans when positive preliminary enrollment decisions are made by VistA.

According to the whistleblowers, in February 2012 Beckley VAMC had a backlog of approximately 8,000 preliminary enrollment decisions that were not properly transferred to the HEC, due to an ongoing unresolved computer error. Because determinations were not transferred to the HEC, these enrollments were never finalized and veterans were never informed of their status. The whistleblowers contend that some individuals on this list initially applied for enrollment as early as 2009. In February 2012, Beckley VAMC administrators reset the system in an attempt to fix the computer error. This caused the automatic transfer of approximately 4,000 of the 8,000 preliminary eligibility determinations to the HEC system. The whistleblowers explained that after the reset, issues continued and veteran data are still not properly transferred to the HEC. The whistleblowers allege that Beckley VAMC currently has 2,500 to 4,000 veterans waiting for eligibility determinations.

After this reset, the whistleblowers reviewed a large number of these transfers and have determined that so far, over 1,000 were wrongly deemed ineligible during preliminary eligibility determinations. These determinations are still under review by the whistleblowers. [redacted] alleged that preliminary determinations were not properly reviewed by Beckley VAMC staff and alerts were not placed on files. Because incorrect preliminary enrollments lacked alerts, HEC did not conduct a review of these eligibility determinations and veterans were wrongly denied enrollment.

[redacted] attributed the lack of preliminary eligibility determination reviews to mismanagement. He contends that [redacted] verbally directed enrollment staff not to review preliminary eligibility determinations and to delete online applications pending for extended periods of time. [redacted] noted that many pending determinations were filed online, via the VA's Online Application for Health Benefits. Agency policy requires enrollment staff to process online applications within a week. [redacted] alleges that hundreds of Beckley VAMC online applications are unprocessed, some dating back years, as a result of [redacted] instructions.

[redacted] also explained that Beckley VAMC staff are not trained on recent changes to enrollment classification criteria. He noted that during the enrollment process, veterans are assigned to a priority group, based on disabilities, service records, and incomes. These groups are used to determine the scope of available care. In 2013, group classification criteria were changed but, according to [redacted], Beckley VAMC staff were never trained on updated regulations. As a result, he alleges that enrollment staff

commit frequent errors when reviewing preliminary enrollment determinations. In addition, [redacted] noted that new enrollment staff receive no formal official training on computer systems and enrollment regulations. The whistleblowers requested training but were denied by [redacted]

The whistleblowers also contend eligible applicants rarely receive proper notice. [redacted] provided a list of examples, with applicant names redacted, where veterans were enrolled but never received notice from HEC or Beckley VAMC that they were eligible for VA medical care until staff in the Rural Health Initiative reviewed their files. [redacted] explained that these patient files indicated that no contact was attempted after their enrollment was approved. *See* Enclosure A. Some of these individuals waited for years before they were contacted by enrollment staff to apprise them of their status. As noted above, the VA targets five to seven days to reach enrollment decisions and apprise applicants of their eligibility.

[redacted] also provided specific examples of veterans who died after their enrollment was improperly rejected but before a subsequent review of their files determined they were eligible. [redacted] explained that starting in September 2013, he and coworkers attempted to contact individuals to notify them of errors and schedule appointments. In five specific instances, [redacted] stated that when Rural Health contacted the veteran to schedule an appointment, family members informed schedulers that the individual had recently died. [redacted] provided application information, with names redacted, showing that these individuals waited between 18 months and eight years for notification. *See* Enclosure B.

These issues and processes appear to violate VHA directives requiring timely and convenient access to medical care. *See* VHA Directive 2006-041. In addition, these problems may have a direct effect on patient health: When enrollment statuses are incorrect or go uncommunicated, applicants are denied VA medical care. This can seriously harm patients with chronic and emergent conditions requiring ongoing medical intervention.

[redacted] observed that the failure to properly review preliminary eligibility determinations may also be linked to the agency wide bonus system based on patient wait times. He noted that Beckley VAMC currently has a veteran population of 14,000, and indicated that the large number of pending enrollments would place a greater strain on the system's ability to provide timely care. This could adversely affect performance bonuses facility managers receive.

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The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not

have the authority to investigate a whistleblower's disclosure; rather, if I determine that there is a substantial likelihood that one of the aforementioned conditions exists, I am required to advise the appropriate agency head of my determination, and the agency head is required to conduct an investigation of the allegations and submit a written report *within 60 days after the date on which the information is transmitted.* 5 U.S.C. § 1213(c).

Upon receipt, I will review the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). I will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

In this case, I have determined that there is a substantial likelihood that the information the whistleblowers provided to OSC discloses a violation of law, rule, or regulation, gross mismanagement, an abuse of authority, and a substantial and specific danger to public health. I am referring this information to you for an investigation of these allegations and a report of your findings within 60 days after the date on which the information is transmitted. OSC will not routinely grant an extension of time to an agency in conducting a whistleblower disclosure investigation. However, OSC will consider an extension request where an agency concretely evidences that it is conducting a good faith investigation that will require more time to successfully complete. By law, this report should be reviewed and signed by you personally. Nevertheless, should you delegate your authority to review and sign the report to the Inspector General, or other agency official, the delegation must be specifically stated and *must include the authority to take the actions necessary under 5 U.S.C. § 1213(d)(5)*. The requirements of the report are set forth at 5 U.S.C. § 1213(c) and (d). A summary of section 1213(d) is enclosed. Please note that where specific violations of law, rule, or regulation are identified, these references are not intended to be exclusive. As you conduct your review of these disclosures and prepare your report, OSC requests that you include information reflecting any dollar savings, or projected savings, and any management initiatives related to these cost savings, that may result from your review.

As a matter of policy, OSC also requires that your investigators interview [redacted] at the beginning of the agency investigation when, as in this case, the whistleblowers consent to the disclosure of their names. As the originator of the complaint, [redacted] can provide additional information and an explanation of his allegations, thereby streamlining the agency investigation. Please note that where specific violations of law, rule, or regulation are identified, these references are not included to be exclusive.

Further, in some cases, whistleblowers who have made disclosures to OSC that are referred for investigation pursuant to 5 U.S.C. § 1213 also allege retaliation for

whistleblowing once the agency is on notice of their claims. I urge you to take all appropriate measures to ensure that those reporting wrongdoing are protected from such retaliation and from other prohibited personnel practices, including informing those charged with investigating [redacted] allegations that retaliation is unlawful and will not be tolerated.

At the outset, or during the course of your investigation, your investigative team may have questions regarding the statutorily mandated report you will deliver to OSC under 5 U.S.C. § 1213. OSC attorneys are available at any time in person or by telephone to discuss OSC's statutory process, expectations for credible, consistent, and complete reports, and for general assistance. Please contact Catherine A. McMullen, Chief, Disclosure Unit, at (202) 254-3604 to initiate this process.

As required by 5 U.S.C. § 1213(e)(3), I will send copies of the report, along with any comments on the report from the whistleblower and any comments or recommendations from me, to the President and the appropriate oversight committees in the Senate and House of Representatives. Unless the report is classified or prohibited from release by law or by Executive Order requiring that information be kept secret in the interest of national defense or the conduct of foreign affairs, OSC will place a copy of the report in a public file in accordance with 5 U.S.C. § 1219(a). To prevent public disclosure of personally identifiable information (PII), OSC requests that you ensure that the report does not contain any sensitive PII, such as Social Security numbers, home addresses and phone numbers, personal e-mail addresses, dates and places of birth, personal financial information, and patient names. OSC does not consider names and titles to be sensitive PII requiring redaction. Agencies are requested not to redact such information in reports provided to OSC for the public file.

Please refer to our file number in any correspondence on this matter. If you need further information, please contact Ms. McMullen. I am also available for any questions you may have.

Sincerely,

Carolyn N. Lerner

Enclosures

cc: The Honorable Richard J. Griffin, Acting Inspector General

Enclosure

Requirements of 5 U.S.C. § 1213(d)

Any report required under subsection (c) shall be reviewed and signed by the head of the agency[1] and shall include:

(1) a summary of the information with respect to which the investigation was initiated;

(2) a description of the conduct of the investigation;

(3) a summary of any evidence obtained from the investigation;

(4) a listing of any violation or apparent violation of law, rule, or regulation; and

(5) a description of any action taken or planned as a result of the investigation, such as:

(A) changes in agency rules, regulations or practices;

(B) the restoration of any aggrieved employee;

(C) disciplinary action against any employee; and

(D) referral to the Attorney General of any evidence of criminal violation.

In addition, we are interested in learning of any dollar savings, or projected savings, and any management initiatives that may result from this review.

To prevent public disclosure of personally identifiable information (PII), OSC requests that you ensure that the report does not contain any sensitive PII, such as Social Security numbers, home addresses and phone numbers, personal e-mail addresses, dates and places of birth, and personal financial information. With the exception of patient names, OSC does not consider names and titles to be sensitive PII requiring redaction. Agencies are requested not to redact such information in reports provided to OSC for inclusion in the public file.

[1] Should you decide to delegate authority to another official to review and sign the report, your delegation must be specifically stated.

Enclosure A
DI-14-3424 and DI-14-3589

- [redacted] - did means test 2012 and told made too much money to use the VA. Rural Health contacted him and brought him in during 2013.
- [redacted] Vet enrolled since 1998 but (HAS) staff did not know he was eligible till Rural Health contacted him and informed him he was eligible and got him scheduled for appointment same day.
- [redacted] - Vet flipped to enrolled next day after applying but did not receive care from Jan 2010 to July 2010 because of lack of notification and determination of enrollment.
- [redacted] - enrolled at Salem VA since 1997 and tried to use us in 2003. Was not told he could use VA and never came back to try again till 2012. He was actually eligible the whole time.
- [redacted]- Vietnam vet that admissions clerk said was ineligible disposition and never used hospital but should have been enrolled.
- [redacted] Purple Heart Recipient that is automatic qualifier for health care was given a rejected type disposition and he never received care here.
- [redacted]- Veteran was actually eligible but given rejected type disposition from staff.
- [redacted] Vietnam vet that was given rejected type disposition from staff and was actually eligible since 2004 when enrolled but not seen till 2008.
- [redacted] - Vet registered in 2005 and given rejected type disposition but was eligible. Did not receive care till 2007.
- [redacted] - Vet was rejected due to net worth from March 06 to July 06 which should not have been the case since net worth is not income and only determines copays not eligibility.
- [redacted] - Vet registered 12/24/08 but did not get letter from HEC till February 2009 saying eligible even though he was enrolled in system 12/25/08. He then contacted hospital in February to schedule appointment.
- [redacted]- Was under income threshold which qualifies for enrollment but over net worth threshold for copay exemption but because of lack of training enrollment staff entered a rejected type disposition that they didn't think he was eligible for care because of net worth.
- [redacted] - Proof that computer is still rejecting veterans when he applied on 3/31/14 but then flipped to enrolled 4/1/14 so if told not eligible that day he would not try to use hospital. Rural Health caught the mistake and got the veteran notified properly.
- [redacted]- Vet was under income threshold but over net worth for copay exemption land was entered as not being eligible because of too much net worth. He flipped to enrolled afterwards.
- [redacted] - Vet registered in 12/2012 but (HAS) staff entered over income threshold disposition because they though the $300,000 in net worth he had put him over threshold but that only affects copays. He was actually eligible by income

Enclosure A
DI-14-3424 and DI-14-3589

- [redacted] - Vet was eligible by regulations but came for appointments and told to go home by staff and not eligible according to computer error. Rural Health had to contact him and apologize and get him set back up for appointments again which resulted in delay of care.
- [redacted] - Vet enrolled 2009 and shows rejected, but Hec enrolled next day. He did not use the VA till 2013. Admissions clerk still said ineligible in 2011 disposition.
- [redacted] - Vet had high net worth and showed 8g rejected but flipped to enrolled. Did not receive care till did c&P and became service connected in 2011.
- [redacted] - High net worth and initially showed rejected and flipped to eligible. Did not receive care till Rural Health 2013.
- [redacted] - Vet flipped from rejected to enrolled in 2010 but admissions clerk never followed up and vet was never seen.
- [redacted] Vet application in 2010 with high income, Enrollment Coordinator did hardship but not seen till 2013.

Enclosure B
DI-14-3424 and DI-14-3589

1. Applied/denied 7/12/10 and [redacted] contacted him 9/2013 and told deceased by family.
2. Applied/denied 6/26/05 and [redacted] contacted him 9/2013 and told deceased by family.
3. Applied/denied 2/22/2011 and [redacted] contacted 9/2013 and told by family deceased.
4. Applied/denied 2/23/12 and [redacted] contacted 9/2013 and told by family deceased.
5. Applied/denied 1/9/2011 and [redacted] contacted 9/2013 and told by family deceased.

- [redacted] - He got rejected initially but was actually eligible and flipped in computer system two days later but nobody contacted him. Rural Health called him and he was deceased.
- [redacted] - He was initially rejected when he applied but should have been eligible and enrolled. When Rural Health contacted him he had already died.
- [redacted] He was rejected when he applied but should have been eligible and enrolled. When Rural Health tried to contact him he was deceased.
- [redacted] Vet was denied care and rejected when applied but should have been eligible and enrolled. When Rural Health tried to contact he was deceased.
- [redacted] He sent a mail in application. Was told he had too much assets and net worth and not eligible for care. He was actually eligible and should have been provided care. He never used VA and when Rural Health contacted him to try and notify and get appointment he was dead.