US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures

Healthcare Inspection | **22-02294-42** | **January 4, 2024**

BE A
VOICE FOR VETERANS
REPORT WRONGDOING
va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review a former Gulf Coast VA Health Care System (system) surgeon's eligibility to provide health care as a participant in the VA's Community Care Network (CCN).[1] During the inspection, the OIG identified related concerns regarding the Veterans Health Administration (VHA) Office of Integrated Veteran Care's (IVC's) and a third-party administrator's (TPA's) reviews of the surgeon's credentialing file and the Marion VA Health Care System's (facility's) deficient management of community care patient safety events.[2]

In 2019, the OIG published a report related to the surgeon's quality of patient care at the system in Biloxi, Mississippi.[3] The OIG determined that system leaders missed opportunities to clearly convey, record, and take action against the surgeon in response to identified clinical competence concerns. Specifically, the system failed to provide the surgeon with a written proposal to terminate VA employment prior to the surgeon's resignation and failed to record the departure as a resignation in lieu of involuntary action.[4] A resignation in lieu of involuntary action would have excluded the surgeon from providing care to veterans, including through the VA community care program.

[1] VHA "provides health care to eligible veterans using a combination of VHA and non-VHA providers and facilities," Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects,* October 2021. VHA utilizes contractors, known as third-party administrators, to develop networks of community providers as a mechanism to purchase care in the community for veterans.

[2] VHA Acting Under Secretary for Health memorandum, "Notification of Program Office Reorganization," September 23, 2021. For the purpose of this report, the OIG refers to the VHA Office of IVC as the program office that oversees VHA community care. The TPA is responsible for ensuring all licensed non-VA providers in the network are credentialed; VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. VHA defines credentialing as "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system." The credentialing file contained the surgeon's credentialing application and the TPA's documentation of review of the application.

[3] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi*, Report No. 17-03399-200, August 28, 2019.

[4] Office of Personnel Management (OPM), chap. 31. "Separations by Other than Retirement," accessed July 11, 2022, https://www.opm.gov/policy-data-oversight/. A resignation is an action that ends employment initiated by the employee. A resignation in lieu of involuntary action is a "separation initiated by the employee under circumstances that meet the definition of 'involuntary separation."

Veteran Care in the Community and Third-Party Administrators

Congress enacted two pieces of legislation, Veterans Access, Choice and Accountability Act of 2014 (Choice Act) and VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), to improve veterans' access to care.[5]

In December 2021, the Government Accountability Office (GAO) published a report exposing vulnerabilities in the controls used by VHA and community care "contractors to identify health care providers who are not eligible to participate in the Veterans Community Care Program (VCCP) [CCN], resulting in the inclusion of potentially ineligible providers."[6] The GAO assessed over 800,000 providers and identified approximately 1,600 potentially ineligible providers.[7] Within the 1,600 providers, the GAO found that VA did not exclude or remove "216 active providers who had a revoked medical license" and "796 active providers who surrendered their licenses."[8] National Practitioner Data Bank (NPDB) defines a voluntary surrender of a license or certification as "a surrender made after a notification of investigation or a formal official request by a federal or state licensing or certification authority for a . . . provider, or supplier to surrender the license or certification."[9]

After publishing the December 2021 report in January 2022, the GAO provided IVC with a list of the approximately 1,600 providers (GAO list) and requested IVC evaluate identified providers' eligibility to participate in the CCN. The OIG reviewed the GAO list and confirmed that the surgeon identified in the OIG 2019 report was among the providers on the list.

During this inspection, the OIG identified multiple failures by one of the TPAs, Optum, and IVC that undermined credentialing and oversight processes, and ultimately allowed the subject surgeon to practice in the VA community care program. First, Optum failed to address concerns identified by a third-party-certified verification organization in the surgeon's 2018 credentialing file. Second, imprecise language in the VA's contract with the TPA did not provide adequate guidance for Optum in determining whether to exclude the surgeon from the CCN. Additionally,

---

[5] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 132 Stat.1393 (2018); VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. VHA defines credentialing as "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system."

[6] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*, GAO-22-103850, December 2021. On March 11, 2022, the report was revised to include VA's response to GAO recommendations.

[7] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*.

[8] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*.

[9] US Department of Health and Human Services, National Practitioner Data Bank, chap. E in *The NPDB Guidebook*, accessed March 7, 2023, https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp. The NPDB is a repository of reports of adverse actions and medical malpractice payments regarding a healthcare practitioner.

IVC failed to conduct a thorough review of the surgeon's credentialing file and identify inconsistencies that should have impacted credentialing decisions after learning of GAO concerns and OIG's inspection focusing on the surgeon. Finally, misapplication of privacy rules prevented Optum's leaders from releasing important information to IVC relevant to the surgeon's voluntary relinquishment of the Florida medical license. Had any one of these failures not occurred, the surgeon likely would have been excluded from participating in the CCN. In November 2022, following the OIG's interview with the IVC Executive Director, the former IVC CCN credentialing supervisor placed the surgeon on hold in the Provider Profile Management System "pending a final determination from the OIG [inspection]."

Optum Failed to Address Concerns in the Surgeon's Credentialing File

The OIG found deficiencies in Optum's credentialing of the surgeon related to requirements in National Committee for Quality Assurance (NCQA) credentialing accreditation standards and Optum's credentialing process.[10] Specifically, Optum did not address concerns identified by the certified verification organization in the 2018 credentialing file.[11]

NCQA standards outline requirements for review and verification of information in a provider's credentialing application.[12] During an interview, Optum's vice president of provider network and credentialing told the OIG that, when indicated, Optum's certified verification organization completes an adverse practitioner checklist and flags concerns related to a provider's education, training, or NPDB findings.

Upon review of the surgeon's 2018 credentialing file, the OIG identified that the surgeon reported having a current active Pennsylvania medical license on the 2018 credentialing application; however, the OIG found the surgeon's Pennsylvania license expired in December 2014.[13] The surgeon also reported employment at a Pennsylvania cancer center for the previous five years; however, the OIG obtained documentation from the center verifying the surgeon resigned from the Pennsylvania cancer center in July 2013. In addition, the surgeon did not report employment at the VA during the previous five years, but the surgeon was employed at the system from August 2013 through December 2017. [14] In the 2018 credentialing file, the OIG

[10] NCQA Standards and Guidelines for Accreditation in Utilization Management, Credentialing and Provider Network 2018.

[11] The Optum vice president of provider network and credentialing told the OIG that Optum contracts with a certified verification organization that is responsible for review of the credentialing application and primary source verification.

[12] NCQA Standards and Guidelines for Accreditation in Utilization Management, Credentialing and Provider Network 2018.

[13] The OIG obtained information from the Pennsylvania Department of State, accessed July 28, 2022, https://www.pals.pa.gov/#/page/searchresult.

[14] Optum Credentialing and Privileging File, Work History and References Information.

identified that the certified verification organization designated an "adverse" status on an adverse practitioner checklist in the surgeon's credentialing file, documented a flag for NPDB reports on the checklist, and noted a copy of the surgeon's current Pennsylvania license was missing from the surgeon's application.[15]

Optum's credentialing committee recommended the surgeon for approval.[16] The OIG requested Optum's credentialing committee meeting minutes to review any discussions or decisions documenting the credentialing committee approval of the surgeon's credentialing. However, Optum reported there were no meeting minutes documenting the surgeon's credentialing.[17] Due to the lack of documentation, the OIG was unable to understand Optum's rationale for approving the surgeon's credentialing.

Imprecise VA TPA Contract Language Used to Determine Surgeon's CCN Eligibility

The OIG found that imprecise language in the VA TPA contract did not provide adequate guidance for Optum in determining whether to exclude the surgeon from the CCN due to the surgeon's voluntary relinquishment of a Florida medical license.

Under the VA TPA contract, Optum "must always confirm" that each CCN provider has certified that

- no state has "terminated" a medical license "for cause," and
- the provider has not "involuntarily relinquished" a medical license after being notified in writing by that state of "potential termination for cause."[18]

According to Section 108 of the MISSION Act, effective June 6, 2019, the Secretary of Veterans Affairs shall "deny or revoke the eligibility of a health care provider to provide non-Department health care services to veterans if the Secretary determines that the health care provider . . .

[15] The OIG was unable to interview the staff member as they were no longer employed at the certified verification organization at the time of the inspection.

[16] Optum's vice president of provider network and credentialing told the OIG that the surgeon was approved for participation in Optum's CCN through the credentialing process.

[17] An Optum staff member acting on behalf of the Optum attorney provided information about the committee meeting minutes to the OIG team. During an interview, the current IVC CCN credentialing supervisor reported having an expectation that the surgeon's file would have been reviewed by Optum's credentialing committee.

[18] Contract No. 36c79119D0005 issued by VA with Optum Public Sector Solutions, Inc., December 28, 2018; Standard Form 1449, Solicitation/Contract/Order for Commercial Items.

violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license." [19]

In 2006, the surgeon voluntarily relinquished the Florida license after being investigated by the Florida Department of Health and notified of a potential termination for cause.[20] According to the Florida Board of Medicine records, the Florida Secretary of Health filed a complaint against the surgeon, in 2006, alleging two violations of Florida licensing law: having a license acted against by the Kentucky state licensing board and failing to report that action had been taken against the license.[21] The Florida Department of Health requested the Florida Board of Medicine to impose discipline it deemed reasonable, up to and including a permanent license revocation.[22] The surgeon had the right to contest a possible license revocation, instead, as part of a settlement, the surgeon agreed to voluntarily relinquish the license and never practice medicine or reapply for a medical license in Florida "to avoid further administrative action."[23] The surgeon agreed to the Board of Medicine's 2006 Final Order, which stated the surgeon's voluntary relinquishment "shall constitute discipline upon [the surgeon's] license."[24]

Although information relating to the 2006 license relinquishment was reflected on an NPDB report in the surgeon's 2018 credentialing file, Optum credentialed the surgeon in 2018 and recredentialed the surgeon in 2021.[25] In an interview with Optum's Chief Medical Officer and in correspondence from another Optum attorney, the OIG confirmed that Optum did not maintain

[19] MISSION Act; US Department of Health and Human Services, NPDB, *The NPDB Guidebook* chap. E, accessed March 7, 2023, www.npdb.hrsa.gov/guidebook/EOverview.jsp. The NPDB definition of a voluntary surrender of a license includes "instances where a . . . provider . . . voluntarily surrenders a license or certification . . . in exchange for a decision by the licensing or certification authority to cease an investigation or similar proceeding, or in return for not conducting an investigation or proceeding, or in lieu of a disciplinary action." According to the NPDB, a voluntary surrender of a license is a loss of license.

[20] Florida Board of Medicine Final Order. The Florida Department of Health is responsible for investigating and prosecuting physician complaints in the state of Florida. The Board of Medicine, which falls under the jurisdiction of the Florida Department of Health, has responsibility for adjudicating a case after the Florida Department of Health investigation of the complaint.

[21] Florida Board of Medicine Final Order. Commonwealth of Kentucky Board of Medical Licensure, The License to practice medicine in the Commonwealth of Kentucky [Agreed Order], June 6, 2005.

[22] Florida Board of Medicine Final Order. The two violations included failing to participate in a quality review of a patient's case who died following a procedure performed by the surgeon and failing to notify Florida Board of Medicine of a Kentucky disciplinary action.

[23] Florida Board of Medicine Final Order.

[24] Florida Board of Medicine Final Order. "License Status Definitions," Florida Board of Medicine, accessed May 18, 2023, www.flboardofmedicine.gov. The OIG found that the Florida Board of Medicine reflected the status of the surgeon's medical license as "DISCP-RELINQ" (disciplinary relinquishment).

[25] The Optum vice president of provider network and credentialing told the OIG that in December 2018, when the VA TPA contract was initiated, Optum's credentialed providers were included in the CCN. At all times relevant to this inspection, an NPDB report was in the surgeon's 2018 Optum credentialing file that revealed that in 2006, the surgeon had relinquished a Florida license. According to Optum's vice president of provider network and credentialing, Optum subsequently obtained the records of the surgeon's license relinquishment from the Florida Board of Medicine.

records demonstrating whether the Florida license relinquishment was considered when these credentialing decisions were made.

The OIG found that the VA TPA contract does not define *involuntary relinquishment*, *loss of a medical license*, or *termination for cause*. Further, the VA TPA contract does not differentiate between disciplinary and non-disciplinary license relinquishments or address whether a provider must be excluded from the CCN if the provider voluntarily relinquishes a medical license after notification of an investigation or a potential license termination for cause. This lack of clarity in the contract may have contributed to Optum's determination that the surgeon was eligible to participate in the CNN.

IVC's Failure to Thoroughly Review the Credentialing File

The OIG determined that the IVC staff charged with oversight of credentialing CCN providers failed to carry out a thorough review of the surgeon's credentialing file. Specifically, IVC staff failed to identify inconsistencies that should have impacted credentialing decisions.

According to VA Community Care, *Annual Provider Network Credentialing Quality Review* standard operating procedure for provider network credentialing, IVC is responsible for monitoring TPAs' "maintenance of an adequate network of high quality CCN credentialed providers."[26] VA's standard operating procedure for community care provider exclusion outlines criteria for excluding providers from VA's CCN that are consistent with the MISSION Act.[27]

During interviews, the former and current IVC CCN credentialing supervisors told the OIG that IVC CCN credentialing staff were responsible for ensuring TPA providers' licenses were current and asserted that credentialing staff reviewed TPAs' compliance with accreditation standards and contract requirements when determining providers' eligibility to be a CCN provider.[28]

Prior to an interview with the IVC Executive Director in October 2022, the OIG shared the surgeon's 2018 and 2021 credentialing files obtained from Optum with the IVC Executive Director. During the interview, the OIG informed the Executive Director of licensure concerns found in the credentialing file. When asked about primary source license verification, the Executive Director reported being unaware whether IVC staff had conducted a primary source

[26] VA Community Care, *Annual Provider Network Credentialing Quality Review Standard Operating Procedure*, August 11, 2020.

[27] VHA Office of Community Care*, Provider Exclusion Standard Operating Procedures*, December 2021; MISSION Act.

[28] The current IVC CCN credentialing supervisor reported having supervisory responsibility over the IVC CCN credentialing staff at the time of the June 2022 interview with the OIG; GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers.* Nationally maintained provider exclusionary lists include the Department of Health and Human Services, Office of the Inspector General List of Excluded Individuals/Entities, General Services Administration System for Award Management, and the Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System.

verification of any of the surgeon's licenses or reviewed the surgeon's credentialing files.[29] When asked whether IVC staff shared any concerns related to the surgeon, the Executive Director told the OIG, "No issues [were] brought to my attention."

The OIG found evidence of multiple IVC reviews of the surgeon's eligibility to be a CCN provider. However, IVC failed to identify inconsistencies in the surgeon's credentialing file that should have impacted credentialing decisions. The OIG limited its review to this provider, but similar failures for IVC to effectively review could have consequences for other providers on the GAO list.

Optum's Misapplication of Privacy Rules

During the inspection, the OIG found that Optum did not provide the surgeon's complete credentialing files to IVC. Specifically, inconsistent with the Privacy Act regulation, Optum did not provide the surgeon's complete NPDB reports, which included the surgeon's voluntary relinquishment of the Florida medical license. Contrary to the VA TPA contract, Optum inappropriately requested that IVC submit a subpoena to Optum for the release of Optum's credentialing committee meeting minutes.

During an interview, the Optum vice president of provider network and credentialing reported "that's a federal state thing or a federal statute that [Optum] can't share NPDBs." When the OIG requested clarification from the IVC Executive Director, an IVC program analyst responded on behalf of the director stating that, "NPDB prohibits sharing query results."

The OIG determined that the Optum vice president of provider network and credentialing's viewpoint regarding providing IVC with documentation related to provider credentialing and IVC's understanding of the ability to obtain NPDB reports from Optum were inaccurate. According to the Privacy Act regulation, Optum was allowed to disclose NPDB records to IVC, a federal agency requesting data concerning a health care provider for the purpose of healthcare oversight.[30] Without the complete NPDB reports, IVC was unaware of the surgeon's Florida medical license action at the time of receipt of the credentialing file from Optum. Additionally, per the VA TPA contract, IVC is not required to subpoena Optum's credentialing committee meeting minutes as VHA's authority to receive and review documents includes those protected under federal privacy laws.[31]

[29] The VA TPA contract does not include specific language requiring TPA primary source license verification; however, the contract requires Optum to comply with NCQA standards for credentialing, which include a requirement for primary source license verification.

[30] Privacy Act; Exempt Record System, 76 *Federal Register* 72325 (Nov. 23, 2011); 45 C.F.R. §5b.11(b)(2)(ii)(L).

[31] Contract No. 36c79119D0005 issued by VA with Optum Public Sector Solutions, Inc., December 28, 2018.

Additional Concern Regarding Deficient Management of Community Care Patient Safety Events

The OIG found that facility staff failed to manage community care patient safety events.[32]

VHA guidance requires facility staff to use the Joint Patient Safety Reporting (JPSR) system to report community care-related patient safety events.[33] VHA guidance also notes that the facility patient safety manager must give feedback to reporters.[34] An IVC patient safety and quality training document indicates that patient safety managers can contact a TPA after submitting a potential quality issue to confirm that a TPA addressed the patient safety event and inquire whether a potential quality issue is "open, ongoing, or closed."[35]

The OIG concluded that the facility's patient safety training did not include completing JPSR event reports for patient safety events in the community. Facility staff who reported community care patient safety events in the JPSR system did not receive feedback on reported events. Additionally, the patient safety manager was unaware of the ability to contact the TPA for updates on the status of a potential quality issue.

The OIG made two recommendations to the Under Secretary for Health related to initiating a review of the surgeon's eligibility to participate in the CCN and reviewing the CCN contracts for consistency with the MISSION Act.

The OIG made four recommendations to the IVC Director related to ensuring Optum's sufficient review of community care providers adverse credentialing files, documentation of CCN provider credentialing decisions, compliance with CCN contract provisions, and verification that providers on the 2021 GAO list are eligible to provide care in the CCN.

The OIG made one recommendation to the Veterans Integrated Service Network Director related to reviewing all VA community care provided by the surgeon.

The OIG made one recommendation to the Facility Director related to ensuring education on using the JPSR system and follow-up on patient safety events related to community care.

---

[32] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022. The OIG considers the terms *patient safety incident*, *events*, and *concerns* interchangeable. This report refers to patient safety-related incidents as patient safety events.

[33] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[34] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021. This guidance was in effect at the time of the review until it was replaced by VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022. The two guidebooks contain similar language related to reporter feedback.

[35] "Patient Safety and Quality (PS/Q) Overview and the Peer Review Process" (PowerPoint),VHA IVC, accessed July 18, 2022, https:dvagov.sharepoint.com. (This website is not publicly accessible.); VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022. A potential quality issue is a patient safety concern related to community care reported to the TPA.

VA Comments and OIG Response

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

CCN	Community Care Network
GAO	Government Accountability Office
IVC	Office of Integrated Veteran Care
JPSR	Joint Patient Safety Reporting
NCQA	National Committee for Quality Assurance
NPDB	National Practitioner Data Bank
OIG	Office of Inspector General
PSM	patient safety manager
PQI	potential quality issue
SLB	state licensing board
TPA	third-party administrator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review a former Gulf Coast VA Health Care System (system) surgeon's eligibility to participate in the VA Community Care Network (CCN).[1] During the inspection, the OIG identified related concerns regarding the Veterans Health Administration (VHA) Office of Integrated Veteran Care's (IVC's), and a third-party administrator's (TPA's), reviews of the surgeon's credentialing file.[2] The OIG also identified a related concern regarding deficient management of community care patient safety events at the Marion VA Health Care System in Illinois (facility), part of the Veterans Integrated Service Network (VISN) 15.[3]

Background

Veteran Care in the Community

Congress enacted two pieces of legislation, Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) and VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), to improve veterans access to care. "As a result, the VA has undergone a major transformation in the way that care is delivered to Veterans with an increased reliance on community-based provider networks."[4]

Veterans Access, Choice, and Accountability Act

Implemented in 2014, the Choice Act allowed eligible veterans to utilize care in the community if they were unable to schedule appointments at a VA facility within 30 days of their preferred or

[1] VHA "provides health care to eligible veterans using a combination of VHA and non-VHA providers and facilities;" Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects,* October 2021. VHA utilizes contractors, known as third-party administrators, to develop networks of community providers as a mechanism to purchase care in the community for veterans.

[2] VHA Acting Under Secretary for Health memorandum, "Notification of Program Office Reorganization," September 23, 2021. For the purpose of this report, the OIG refers to the VHA Office of IVC as the program office that oversees VHA community care. The credentialing file contained the surgeon's credentialing application and the TPA's documentation of review of the application.

[3] The surgeon provided care to patients referred to community care from Marion VA Health Care System.

[4] Kristin M. Mattocks et al., "Understanding VA's Use of and Relationships with Community Care Providers Under the MISSION Act," Medical Care (June 2021): Volume 59, Number 6 Suppl 3; Veterans Access, Choice and Accountability Act of 2014, Pub. L. No. 113-146 § 128 Stat. 1754 (2014); VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 132 Stat. 1393 (2018).

clinically indicated date or lived more than 40 miles from a VA medical facility.[5] The Choice Act expired on June 6, 2019, with the implementation of the MISSION Act of 2018.[6]

MISSION Act

The MISSION Act established a permanent community care program to provide health care through non-VA providers.[7] The MISSION Act consolidated VA's multiple community care programs into one consolidated program in an effort to provide veterans more community care and "robust care coordination."[8] The MISSION Act also detailed requirements related to VA's monitoring of quality of community care provided to veterans and established the criteria for excluding certain healthcare providers from participating in the community care program.[9]

Third-Party Administrators and Community Care Networks

VA utilizes contractors, known as TPAs, to develop networks of community providers as a mechanism to purchase care in the community for veterans. The TPA is responsible for ensuring all licensed non-VA providers are credentialed to provide care within the scope of their license.[10] Eligible veterans who choose care in the community select providers within the TPA-managed CCN. The CCN consists of five regional networks that cover the United States and its territories.[11]

On December 28, 2018, VA announced awarding Optum Public Sector Solutions, Inc. (Optum) a contract to serve as the TPA for regions 1, 2, and 3.[12] On August 8, 2019, VA announced that TriWest Healthcare Alliance was awarded the contract to manage regions 4 and 5.[13] Figure 1 is a map of the United States and its territories with the division of the five regions and associated TPA.

---

[5] VHA, "Ten Things to Know About the Choice Program" (web page), accessed October 13, 2022, https://www.va.gov/HEALTH/NewsFeatures/2015/July/10-Things-to-Know-About-Choice-Program.asp.

[6] VA Office of Public Affairs, "Veteran Community Care – Sunset of Veterans Choice Program, VA MISSION Act of 2018 Fact Sheet," May 2019; MISSION Act.

[7] MISSION Act.

[8] VHA, "Community Care Network (CCN) Fact Sheet," Updated January 21, 2022.

[9] MISSION Act.

[10] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. VHA defines credentialing as "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system."

[11] VHA, "Community Care Network (CCN) Fact Sheet."

[12] During an interview, Optum's vice president of provider network and credentialing stated that Optum is an organization within UnitedHealth Group, Inc; VHA, "Community Care Network (CCN) Fact Sheet."

[13] VHA Office of Community Care, "Community Care Network (CCN) - Regions 1-5 For Veterans Fact Sheet," November 4, 2021.

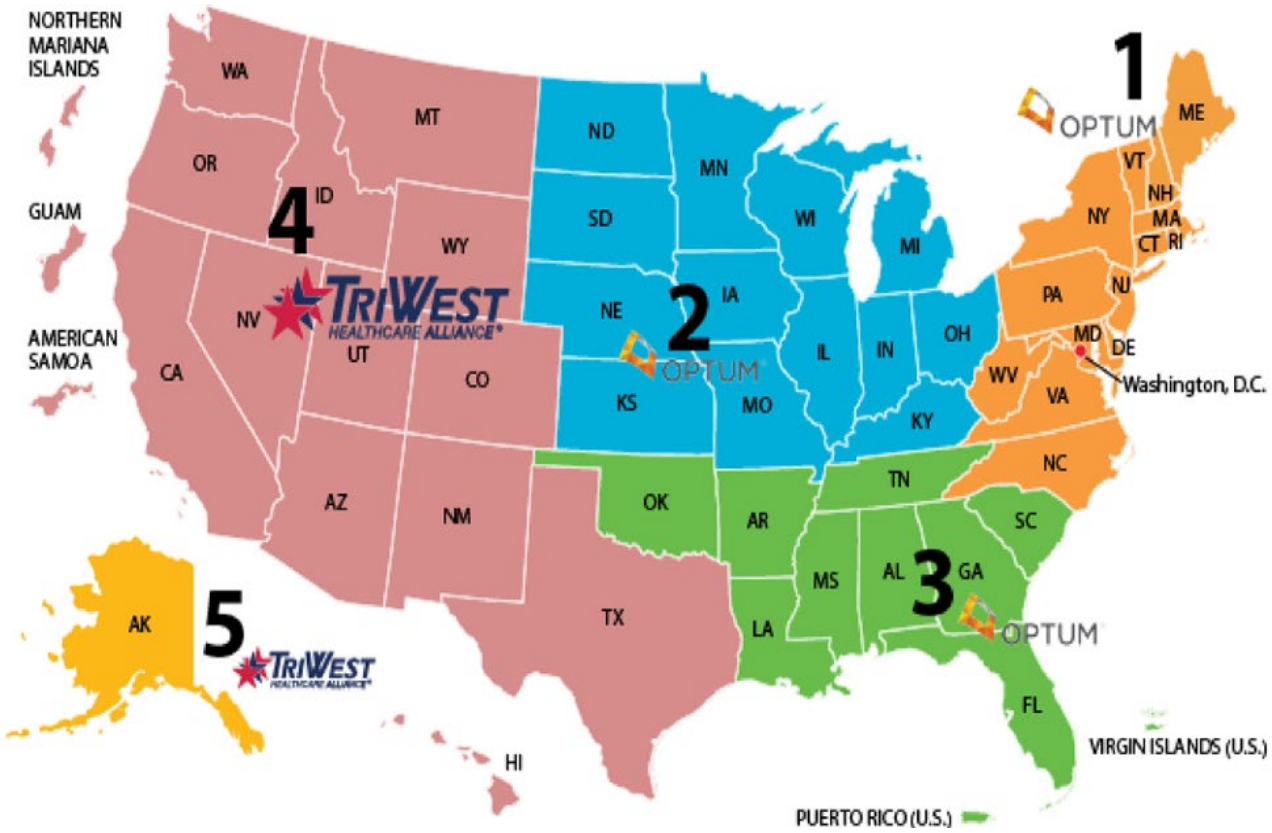

Figure 1. *Five VA regional CCNs.*
*Source: "*Community Care Network - Community Care (va.gov)*," accessed August 22, 2022, va.gov.*

VA Community Care Program Administration

Throughout the growth of VA's community care program, VHA established multiple program offices to oversee the administration of community care programs. In September 2021, VHA's Acting Under Secretary for Health notified VHA senior leaders of a plan to combine the program offices of Community Care and Veterans Access to Care into one program office. In May 2022, these program offices were restructured as IVC.[14]

Prior OIG Reports

In 2019, the OIG published a report related to the surgeon's quality of patient care at the system in Biloxi, Mississippi.[15] The OIG conducted a site inspection in April 2018, at which time the

[14] VHA Acting Under Secretary for Health memorandum, "Notification of Program Office Reorganization," September 23, 2021.

[15] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi*, Report No. 17-03399-200, August 28, 2019.

OIG team learned that system leaders had verified concerns regarding the surgeon's quality of care for two patients.

The OIG assessed system leaders' actions after verifying these care deficiencies, including the oversight of quality management processes. The OIG determined that system leaders missed opportunities to clearly convey, record, and take action against the surgeon in response to the facility's identified concerns. Specifically, the system failed to provide the surgeon with a written proposal to terminate VA employment prior to the surgeon's resignation and record the departure as a resignation in lieu of involuntary action.[16] A resignation in lieu of involuntary action would have excluded the surgeon from the community care program.

The OIG made 19 recommendations, including two recommendations related to state licensing board reporting.[17] As of September 22, 2020, all recommendations were closed.

Concerns

The OIG conducted an inspection of the processes that allowed the former system surgeon to treat VA patients as a community care provider. Specifically, the healthcare inspection focused on

- the undermining of Optum's credentialing and oversight processes, which allowed the surgeon to practice in the Optum CCN; and
- IVC's review of the surgeon's CCN credentialing file.

During the inspection, the OIG also identified a related concern regarding deficiencies in the facility's management of community care patient safety events.

Scope and Methodology

The OIG initiated the inspection on April 26, 2022, and conducted virtual interviews from June 21 through October 31, 2022. The period of review was November 26, 2018, through March 24, 2023.

The OIG interviewed the IVC Executive Director, Integrated External Networks (Executive Director), staff formerly or currently supervising IVC CCN credentialing staff, and an IVC health system specialist. The OIG also interviewed facility leaders and staff, including a community care physician, a primary care leader, a primary care nurse practitioner (nurse

[16] Office of Personnel Management (OPM), Chap. 31. "Separations by Other than Retirement," accessed July 11, 2022, https://www.opm.gov/policy-data-oversight/. A resignation is an action that ends employment initiated by the employee. A resignation in lieu of involuntary action is a "separation initiated by the employee under circumstances that meet the definition of 'involuntary separation.'"

[17] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi*.

practitioner), and a surgical provider, as well as a patient safety manager (PSM), Optum Chief Medical Officer, Optum vice president of provider network and credentialing, and Optum senior associate general counsel (Optum attorney) were also interviewed.[18]

The OIG reviewed relevant federal law, the VA TPA contract, VHA directives, handbooks, and memorandums as well as OIG and Government Accountability Office (GAO) reports, community care standards and guidelines, accreditation standards, Optum credentialing plans, personnel and credentialing information, personnel and state licensing board (SLB) documents obtained by subpoena, and Joint Patient Safety Reporting (JPSR) documents.[19] The OIG also reviewed entries in VA's Provider Profile Management System and National Practitioner Data Bank (NPDB) reports.[20]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[18] Optum's vice president of provider network and credentialing told the OIG of being the senior director of provider network and credentialing for a year before transitioning to the vice president of provider network and credentialing position in January 2021.

[19] MISSION Act; Choice Act § 128; VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021. JPSR is VHA's patient safety event reporting system; VHA memorandum, *Notification of Program Office Reorganization*, September 23, 2021. During the inspection, the OIG obtained 2018 and 2021 provider credentialing files from Optum and IVC. The files obtained from Optum had complete NPDB reports while the files from IVC had NPDB summary reports.

[20] Provider Profile Management System (PPMS) Reference and Updated Guide. Provider Profile Management System is a repository of available CCN providers available to provide community care services. US Department of Health and Human Services, accessed June 17, 2022, https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp.The NPDB is a repository of reports of adverse actions and medical malpractice payments regarding healthcare practitioners.

Inspection Results

The OIG identified multiple failures by one of the TPAs, Optum, and IVC that undermined credentialing and oversight processes and ultimately allowed the subject surgeon to practice in the VA community care program. First, Optum failed to evaluate concerns identified by the certified verification organization in the surgeon's 2018 credentialing file. Second, imprecise language in the VA TPA contract did not provide guidance for Optum in determining whether to exclude the surgeon from the CCN. Additionally, IVC failed to conduct a thorough review of the surgeon's credentialing file and identify inconsistencies that should have impacted credentialing decisions after learning of GAO concerns and OIG's inspection focusing on the surgeon. Finally, misapplication of privacy rules prevented Optum's leaders from releasing important information to IVC relevant to the surgeon's voluntary relinquishment of a Florida license. Had any of these failures not occurred, the surgeon likely would not have been permitted to participate in the CCN.

1. Undermining of Optum's Credentialing and Oversight Processes

Optum Failed to Address Concerns in Surgeon's Credentialing File

The OIG found deficiencies in Optum's credentialing of the surgeon related to requirements in National Committee for Quality Assurance (NCQA) credentialing accreditation standards and Optum's credentialing process.[21] Specifically, Optum did not address concerns identified by a third-party-certified verification organization in the 2018 credentialing file.[22]

NCQA standards require an organization review and verify information in a provider's credentialing application.[23] Optum's vice president of provider network and credentialing told the OIG that, when indicated, Optum's certified verification organization completes an adverse practitioner checklist, and flags concerns related to a provider's education, training, or any NPDB findings. The vice president further stated that the concerns are reviewed by the credentialing committee.[24]

[21] NCQA, *Standards and Guidelines for Accreditation in Utilization Management*, Credentialing and Recredentialing Standards, effective for surveys beginning on or after July 1, 2018.

[22] The Optum vice president of provider network and credentialing told the OIG that Optum contracts with a certified verification organization that is responsible for review of the credentialing application and primary source verification.

[23] NCQA, *Standards and Guidelines for Accreditation in Utilization Management*.

[24] In an interview with the OIG, the Optum vice president of provider network and credentialing reported that Optum's certified verification organization conducts verification of the application information. The Optum leader described that an adverse practitioner checklist includes "red flag" items identified during the credentialing process and that "red flags" are reviewed by the credentialing committee.

Through a review of the surgeon's 2018 credentialing file, the surgeon reported having a current active Pennsylvania medical license; however, the OIG found the surgeon's Pennsylvania license expired in December 2014.[25] The surgeon also reported employment at a Pennsylvania cancer center for the previous five years, however, the OIG obtained documentation from the center verifying the surgeon resigned from the Pennsylvania cancer center in July 2013. In addition, the surgeon did not report employment at the VA, but the surgeon was employed at the system from August 2013 through December 2017.

In the 2018 credentialing file, the OIG identified that the certified verification organization designated an "adverse" status on an adverse practitioner checklist in the surgeon's credentialing file.[26] The OIG also identified that the certified verification organization documented a flag for NPDB reports on the checklist and that a copy of the surgeon's current Pennsylvania license was missing from the surgeon's application.

Optum's credentialing committee recommended the surgeon for approval.[27] The OIG requested credentialing committee meeting minutes from Optum to validate any review, discussions, or decisions from the committee regarding the surgeon's credentialing. However, Optum reported there were no meeting minutes documenting the surgeon's credentialing.[28]

The OIG concluded that Optum did not document their review or the actions taken after the certified verification organization designated the surgeon's credentialing file as adverse. The OIG would have expected to see documentation of Optum's review of the "adverse" credentialing file per Optum's reported process. Due to the lack of documentation, the OIG was unable to determine Optum's rationale for approving the surgeon's credentialing.

Imprecise VA TPA Contract Language Used to Determine Surgeon's CCN Eligibility

The OIG found that imprecise language in the VA TPA contract did not provide adequate guidance for Optum in determining whether to exclude from the CCN the surgeon, who had voluntarily relinquished a Florida medical license, which the licensing board identified as a form

[25] The OIG obtained information from the Pennsylvania Department of State, accessed July 28, 2022, https://www.pals.pa.gov/#/page/searchresult.

[26] The OIG was unable to interview the staff member, who was no longer employed at the certified verification organization at the time of the inspection.

[27] Optum's vice president of provider network and credentialing told the OIG that the surgeon was approved for participation in Optum's CCN through the credentialing process.

[28] An Optum staff member acting on behalf of the Optum attorney provided information about the committee meeting minutes to the OIG team. During an interview, the current IVC CCN credentialing supervisor reported having an expectation that the surgeon's file would have been reviewed by Optum's credentialing committee.

of discipline. The OIG determined that a contract modification may be required to ensure the requirements of the MISSION Act are satisfied.[29]

Under the VA TPA contract, Optum "must always confirm" that each CCN provider has certified that

- no state has "terminated" a medical license "for cause," and
- the provider has not "involuntarily relinquished" a medical license after being notified in writing by that state of "potential termination for cause."

If any state in which the provider is licensed has terminated a license for cause, Optum must notify VA and take necessary actions to remove the surgeon from the CCN.[30] According to Section 108 of the MISSION Act, effective June 6, 2019, the Secretary of VA shall "deny or revoke the eligibility of a health care provider to provide non-Department health care services to veterans if the Secretary determines that the health care provider. . . violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license."[31]

NPDB defines a voluntary surrender of a license or certification as "a surrender made after a notification of investigation or a formal official request by a federal or state licensing or certification authority for a . . . provider, or supplier to surrender the license or certification." "The definition also includes those instances where a. . . provider. . . voluntarily surrenders a license or certification . . . in exchange for a decision by the licensing or certification authority to cease an investigation or similar proceeding, or in return for not conducting an investigation or proceeding, or in lieu of a disciplinary action." According to the NPDB, a voluntary surrender of a license is a loss of license.[32]

In 2006, the surgeon voluntarily relinquished the Florida license after being investigated by the Florida Department of Health and notified of a potential termination for cause.[33] The Florida Board of Medicine records show that the Florida Secretary of Health filed a complaint against the surgeon in 2006, alleging two violations of Florida licensing law: having a license acted against by the Kentucky SLB and failing to report that action had been taken against the

[29] MISSION Act. For the purposes of this report the OIG considers the relinquishment, surrender, and revocation of a medical license in disciplinary actions to be a loss of license.

[30] Contract No. 36c79119D0005 issued by VA with Optum Public Sector Solutions, Inc., December 28, 2018; Standard Form 1449, "Solicitation/Contract/Order for Commercial Items."

[31] MISSION Act.

[32] US Department of Health and Human Services, National Practitioner Data Bank, *The NPDB Guidebook* chap. E, accessed March 7, 2023, https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp.

[33] Florida Board of Medicine Final Order. The Florida Department of Health is responsible for investigating and prosecuting physician complaints in the state of Florida. The Board of Medicine, which falls under the jurisdiction of the Florida Department of Health, has responsibility for adjudicating a case after the Florida Department of Health investigation of the complaint.

license.[34] The Florida Department of Health requested the Florida Board of Medicine to impose discipline it deemed reasonable, up to and including a permanent license revocation.[35] The surgeon had the right to contest a possible license revocation, instead, as part of a settlement, the surgeon agreed to voluntarily relinquish the license, and never practice medicine or reapply for a medical license in Florida, "to avoid further administrative action."[36] As agreed to by the surgeon, the Board of Medicine's 2006 Final Order states that the surgeon's voluntary relinquishment "shall constitute discipline upon [the surgeon's] license."[37]

The Florida Department of Health reported to the NPDB the "voluntary surrender" of the surgeon's Florida medical license as a form of discipline.[38]

Although information relating to the 2006 license relinquishment was reflected on an NPDB report in the surgeon's 2018 credentialing file, Optum credentialed the surgeon for the CCN in 2018 and recredentialed the surgeon in 2021.[39] In an interview with the Optum's Chief Medical Officer and in correspondence from another Optum attorney, the OIG confirmed that Optum did not maintain records demonstrating whether the Florida license relinquishment was considered when these credentialing decisions were made. According to the Optum vice president of provider network and credentialing, Optum had obtained the records of the surgeon's license relinquishment from the Florida Board of Medicine at the time of their response to the OIG team's inquiry in January 2023.

The OIG asked Optum's vice president of provider network and credentialing why the surgeon was determined to be eligible to participate in the CCN after the VA TPA contract was initiated in December 2018. Optum's vice president of provider network and credentialing stated that the VA TPA contract did not require exclusion of the surgeon from the CCN because the surgeon voluntarily relinquished the Florida license to avoid further administrative action. Optum's Chief

[34] Florida Board of Medicine Final Order. The two violations included failing to participate in a quality review of a patient's case who died following a procedure performed by the surgeon and failing to notify the Florida Board of Medicine of a Kentucky disciplinary action. Commonwealth of Kentucky Board of Medical Licensure, The License to practice medicine in the Commonwealth of Kentucky [Agreed Order], June 6, 2005.

[35] Florida Board of Medicine Final Order.

[36] Florida Board of Medicine Final Order.

[37] Florida Board of Medicine Final Order. "License Status Definitions," Florida Board of Medicine, accessed May 18, 2023, www.flboardofmedicine.gov. The OIG found that the Florida Board of Medicine reflected the status of the surgeon's medical license as "DISCP-RELINQ" (disciplinary relinquishment).

[38] Florida Board of Medicine, "License Status Definitions," Florida Board of Medicine, accessed May 18, 2023, www.flboardofmedicine.gov. Florida does not permit a voluntary license relinquishment in a disciplinary action. That option was only available in non-disciplinary cases.

[39] The Optum vice president of provider network and credentialing told the OIG that in December 2018, when the VA TPA contract was initiated, Optum's credentialed providers were included in the CCN. At all times relevant to this inspection, an NPDB report was in the surgeon's 2018 Optum credentialing file that revealed that in 2006, the surgeon had relinquished a Florida license. According to Optum's vice president of provider network and credentialing, Optum subsequently obtained the records of the surgeon's license relinquishment from the Florida Board of Medicine.

Medical Officer reported having an understanding that a voluntary relinquishment of a license would not exclude a provider from participating in a CCN, explaining that providers may voluntarily relinquish a medical license in a state because they are no longer practicing in that state.

While's Optum's interpretation may be understandable based on the language used in the surgeon's voluntary relinquishment of license and the VA TPA contract, it appears contrary to the circumstances in this case. This was not a situation in which the surgeon elected to relinquish the license for matters of convenience (i.e., to avoid continuing medical education requirements, or state licensure fees), retirement, or illness. Rather, the relinquishment was considered disciplinary as evidenced by the Florida Board of Medicine's final order and Florida Department of Health's report to the NPDB.[40]

As noted earlier, the MISSION Act requires the Secretary of VA to exclude from the CCN community care providers who violate a state's licensing laws to such an extent that they lose their medical license.[41] VA has contracted with TPAs to have responsibility for excluding providers who have a license terminated for cause or who involuntarily relinquish a license after receiving notice by a state of a potential termination; however, the OIG found that the VA TPA contract does not define *involuntary relinquishment*, or *termination for cause*. Nor does the VA TPA contract differentiate between disciplinary and non-disciplinary license relinquishments. Finally, the VA TPA contract does not address whether a provider must be excluded from the CCN if the provider voluntarily relinquishes a medical license after notification of an investigation or a potential license termination for cause. While the NPDB includes *voluntary surrender* within its definition of a *loss of a medical license*, the VA TPA contract does not address or define either term. [42]

The OIG concluded that imprecise language in the VA TPA contract did not provide adequate guidance for Optum to determine whether to exclude the surgeon from the CCN, and that a contract modification may be required to satisfy the requirements of the MISSION Act. The OIG opines that, to be consistent with the MISSION Act, VA should modify the VA TPA contract to exclude providers from the CCN who have a license terminated for cause, including a voluntary relinquishment or surrender of a medical license in a disciplinary action.

[40] Florida Board of Medicine Final Order.

[41] MISSION Act.

[42] US Department of Health and Human Services, National Practitioner Data Bank, chap. E in *The NPDB Guidebook*, accessed March 7, 2023, www.npdb.hrsa.gov/guidebook/EStateLicensureActions.jsp#VoluntarySurrendershrsa.gov.

2. IVC's Failure to Thoroughly Review the Credentialing File

The OIG determined that the IVC staff charged with oversight of the CCN provider credentialing failed to carry out a thorough review of the surgeon's credentialing file. During the course of the inspection, IVC staff and leaders reported conducting multiple reviews of the surgeon's eligibility to be a CCN provider, however, the staff and leaders failed to identify inconsistencies that should have impacted credentialing decisions after learning of GAO's concerns and OIG's inspection focusing on the surgeon.

According to VA Community Care, *Annual Provider Network Credentialing Quality Review* standard operating procedure, IVC is responsible for monitoring TPAs' "maintenance of an adequate network of high quality CCN credentialed providers."[43] VHA's standard operating procedure for community care provider exclusion outlines criteria for excluding providers from VA's CCN that are consistent with the MISSION Act.[44]

In December 2021, the GAO published a report exposing vulnerabilities in the controls used by VHA and community care "contractors to identify health care providers who are not eligible to participate in the Veterans Community Care Program (VCCP) [CCN], resulting in the inclusion of potentially ineligible providers."[45] The GAO assessed over 800,000 providers and identified approximately 1,600 potentially ineligible providers.[46] Within the 1,600 providers, the GAO found that VA did not exclude or remove "216 active providers who had a revoked medical license" and "796 active providers who surrendered their licenses"[47]

After publishing the December 2021 report in January 2022, the GAO provided IVC with the list of approximately 1,600 providers (GAO list) and requested IVC evaluate identified providers' eligibility to participate in the CCN. The OIG reviewed the GAO list and confirmed that the surgeon was among the providers on the list.

The OIG interviewed the former and current IVC CCN credentialing supervisors responsible for evaluating the GAO list and overseeing CCN provider credentialing. The OIG also reviewed documentation related to IVC's evaluation of the surgeon's credentialing. During interviews, the former and current IVC CCN credentialing supervisors told the OIG that IVC CCN credentialing

[43] VA Community Care, *Annual Provider Network Credentialing Quality Review Standard Operating Procedure*, August 11, 2020.

[44] VHA Office of Community Care, *Provider Exclusion Standard Operating Procedures*, December 2021; MISSION Act.

[45] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*, GAO-22-103850, December 2021. On March 11, 2022, the report was revised to include VA's response to GAO recommendations.

[46] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*.

[47] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*.

staff were responsible for ensuring TPA providers' licenses were current. Additionally, former and current IVC CCN credentialing supervisors asserted that credentialing staff reviewed TPAs' compliance with accreditation standards and contract requirements; including reviewing licenses, national provider exclusionary lists, and determining providers' eligibility to be CCN providers.[48]

IVC staff and leaders provided evidence of 10 IVC reviews of the surgeon's eligibility to be a CCN provider:

- In March 2022, IVC CCN credentialing staff reviewed provider exclusionary lists and state licenses for providers on the GAO list, including the surgeon.
- In April 2022, IVC requested Optum to review CCN providers, including the surgeon. IVC placed the surgeon on hold in the Provider Profile Management System.[49]
- In June 2022, the former IVC CCN credentialing supervisor told the OIG that the surgeon was not on Optum's "list of providers with potentially adverse actions."
- Also in June 2022, after reviewing the surgeon's credentialing file received from Optum, an IVC health system specialist identified that the surgeon answered "yes" to having sanctions or NPDB actions, VA was not listed on any of the surgeon's previous job history, and a need to inquire whether Optum's credentialing committee conducted a review of the surgeon's file.
- In July 2022, IVC removed the surgeon's hold status in the Provider Profile Management System. [50]
- In August 2022, an IVC health system specialist reviewed the Kentucky SLB's June 6, 2005, Agreed Order, and told the OIG that "[the action] wasn't necessarily punitive."[51]

[48] The current IVC CCN credentialing supervisor reported having supervisory responsibility over the IVC CCN credentialing staff at the time of the June 2022 interview with the OIG. GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers.* Nationally maintained provider exclusionary lists include the Department of Health and Human Services, Office of the Inspector General List of Excluded Individuals/Entities, General Services Administration System for Award Management and the Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System.

[49] At the time of the former IVC CCN credentialing supervisor's interview with the OIG in June 2022, Optum had not completed the review of the surgeon. Changes to a provider's CCN eligibility status are made in the Provider Profile Management System. In December 2022, an IVC program staff member told the OIG that a hold status in Provider Profile Management System does not discontinue previously approved care authorizations. At that time, there were two previously approved authorizations, which allowed the surgeon to continue to provide community care.

[50] The acting IVC CCN credentialing supervisor told the OIG that on July 7, 2022, IVC removed the surgeon's hold. The current IVC CCN credentialing supervisor told the OIG that the acting IVC CCN credentialing supervisor was assigned in August 2022.

[51] Commonwealth of Kentucky Board of Medical Licensure, The License to practice medicine in the Commonwealth of Kentucky [Agreed Order], June 6, 2005.

The IVC health system specialist notified the acting IVC CCN credentialing supervisor of the Kentucky SLB license action.

- Also in August, the current IVC CCN credentialing supervisor requested information from Optum regarding any Pennsylvania license actions. Optum credentialing staff member reported having "no record of any licensing sanctions in [Pennsylvania]."
- In September 2022, an IVC program analyst told the OIG that IVC checked the surgeon's Pennsylvania and Kentucky licenses.
- In November 2022, following the OIG's interview with IVC Executive Director, the former IVC CCN credentialing supervisor placed the surgeon on hold in the Provider Profile Management System "pending a final determination from the OIG [inspection]."
- In February 2023, IVC responded to OIG's request of IVC for evidence of verification of the surgeon's Pennsylvania license. IVC reported that the surgeon had a Pennsylvania license from July 26, 2012–December 31, 2014.

Ultimately, IVC did not identify any negative findings for the surgeon.

During interviews with the former and current IVC CCN credentialing supervisors the OIG asked what information was checked related to the surgeon's medical licenses and received varying responses:

- "We were just verifying that single license in Kentucky."
- "If [the surgeon] had more than one license in one state, [IVC CCN credentialing staff] . . . were not verifying it [the additional license] at that time."
- "the TPA are the ones that are doing the primary source verification, they are the owners of the National Provider Data Bank query, which would be the source of information to determine whether a license had been lost. We do not have access to that and it's not our account that is with NPDB."

The current IVC CCN credentialing supervisor also provided an email discussion with an IVC health system specialist related to discussing a review of the surgeon. The IVC health system specialist reported to the IVC CCN credentialing supervisor,

> "We can ask Optum to provide the full credentialing file to check for any. . . [NPDB actions]. . . as we [IVC CCN staff] don't have. . . [the surgeon's] SSN [social security number], but an NPDB report would have likely shown up on one of the licensing databases that we [IVC CCN credentialing staff] reviewed."

Prior to an interview with the IVC Executive Director in October 2022, the OIG shared the surgeon's 2018 and 2021 credentialing files obtained from Optum with the Executive Director. During the interview, the OIG informed the Executive Director of licensure concerns found in the credentialing files. When asked about primary source license verification, the Executive

Director reported being unaware whether IVC staff had conducted a primary source verification of any of the surgeon's licenses or reviewed the surgeon's credentialing file.[52] When asked whether IVC staff shared any concerns related to the surgeon, the Executive Director told the OIG, "no issues [were] brought to my attention."

The OIG found that the current IVC CCN credentialing supervisor requested a review of the surgeon's credentialing file in June 2022, five months after the GAO requested IVC conduct a review of providers who were potentially ineligible to provide community care to veterans. Later that month, an IVC health system specialist reviewed the surgeon's credentialing file. In addition, IVC provided the OIG with evidence of primary source verification of the surgeon's medical licenses approximately12 months after the GAO requested review of identified providers, including the surgeon's eligibility to participate in the CCN. Further, the OIG found that despite 10 reviews prompted by GAO concerns and despite learning of OIG's inspection focusing on the surgeon, IVC failed to identify inconsistencies in the surgeon's credentialing file that should have impacted credentialing decisions. The OIG limited its review to this provider, but similar failures for IVC to effectively review could have consequences for other providers on the GAO list that is detailed in this report.

Optum's Misapplication of Privacy Rules

The OIG found that Optum did not provide the surgeon's complete credentialing files to IVC after the current IVC CCN credentialing supervisor requested an IVC health system specialist to review the surgeon's credentialing file in June 2022. Specifically, Optum did not provide the surgeon's complete NPDB reports, which included the surgeon's voluntary relinquishment of the Florida license. Optum also inappropriately requested that IVC submit a subpoena to Optum for the release of Optum's credentialing committee meeting minutes.

During the inspection, the OIG received copies of the surgeon's 2018 and 2021 credentialing files from both Optum and IVC.[53] After completing a review of all files, the OIG found that the 2018 and 2021 credentialing files the OIG obtained from IVC contained only summary NPDB reports and not the complete NPDB reports available in the 2018 and 2021 credentialing files the

[52] The VA TPA contract does not include specific language requiring TPA primary source license verification; however, the contract requires Optum to comply with NCQA standards for credentialing, which include a requirement for primary source license verification. NCQA requires that Optum's credentialing policies include criteria for credentialing and re-credentialing, managing credentialing files, and monitoring provider license sanctions. The IVC Executive Director told the OIG that after IVC's review of the GAO list, IVC requested Optum to modify their policy to include an increase in frequency of reviews of providers' licenses beyond their initial enrollment in CCN and to include all states of licensure in the NPDB sanctions review, instead of just the state in which a provider requested to practice. The OIG confirmed that in 2021, Optum's credentialing plan was changed to include a monthly review of federal and state sanctions of providers "throughout the duration of [their] network participation."

[53] In mid-June 2022, an IVC staff member requested the surgeon's full credentialing file from Optum and indicated "this is regarding an OIG request." Six days later, Optum provided the surgeon's credentialing file to IVC.

OIG obtained from Optum. Consequently, IVC did not have information regarding the surgeon's voluntary relinquishment of the Florida license, which was only available in a detailed NPDB report.

The Privacy Act regulation allows for the disclosure of NPDB records to federal agencies requesting data concerning a health care provider for the purpose of investigations, audits, evaluations, and inspections related to the delivery of health care.[54] Further, federal regulation authorizes disclosure of NPDB reports to "agencies. . . that request information on licensure. . . actions, any other negative actions or findings. . . for the purposes of determining the fitness of individuals to provide health care services, protecting the health and safety of individuals receiving health care through programs administered by the requesting agency. . . ."[55]

The VA TPA contract requires Optum to provide IVC access to documentation related to reviews of Optum's accreditation and credentialing of providers within the CCN. This documentation must be provided within five business days of notification of a review.[56]

During an interview, the Optum vice president of provider network and credentialing reported "that's a federal state thing or a federal statute that [Optum] can't share NPDBs." When the OIG requested clarification from the IVC Executive Director regarding access to a CCN provider's NPDB information, a second IVC program analyst provided a response on behalf of the director that "NPDB prohibits sharing query results" and provided a reference to the NPDB Guidebook that "in a delegated credentialing arrangement, the health care entity that delegates its credentialing responsibilities . . . is not considered part of the credentialing process and is prohibited from receiving NPDB query results."[57] Contrary to Optum's claim, VHA has authority to receive and review NPDB documents according to federal privacy laws.[58]

Further, the IVC program analyst told the OIG that IVC had requested information from Optum pertaining to the surgeon's credentialing information, including Optum credentialing committee minutes. In response, an Optum credentialing staff member indicated that Optum required a

[54] Privacy Act; Exempt Record System; 45 C.F.R. §5b.11(b)(2)(ii)(L); 45 C.F.R. Section 60.18(a)(2)."

[55] Privacy Act; Exempt Record System, 76 *Federal Register* 72325 (Nov. 23, 2011); 45 C.F.R. §5b.11(b)(2)(ii)(L); 45 C.F.R. Section 60.18(a)(2).

[56] Contract No. 36c79119D0005 Issued by VA with Optum Public Sector Solutions, Inc., December 28, 2018.

[57] US Department of Health and Human Services, National Practitioner Data Bank, *The NPDB Guidebook* chap. E, accessed March 7, 2023,www.npdb.hrsa.gov/guidebook/EOverview.jsp.

[58] Privacy Act; Exempt Record System, 45 C.F.R. §5b.11(b)(2)(ii)(L); 45 C.F.R. §5b.11(b)(2)(ii)(L); 45 C.F.R. Section 60.18(a)(2).

subpoena to release Optum's credentialing committee minutes to IVC. Per VA TPA contract, IVC is not required to subpoena Optum's credentialing committee minutes.[59]

The OIG determined that the Optum vice president of provider network and credentialing's viewpoint regarding providing IVC with documentation related to the provider's credentialing and IVC's understanding of the ability to obtain NPDB reports from Optum were inaccurate. Without the complete NPDB reports, IVC was unaware of the surgeon's Florida medical license action at the time of receipt of the credentialing file from Optum.

3. Additional Concerns Regarding Deficient Management of Community Care Patient Safety Events

The OIG found that facility staff failed to manage community care patient safety events. Specifically, a primary care leader and the nurse practitioner did not know that community care patient safety events required documenting in the JPSR system.[60] Additionally, facility staff who did report community care patient safety events in the JPSR system did not receive status updates. The OIG found that the PSM did not obtain status updates on patient safety events that were reported to the TPA.

VHA guidance requires facility staff use the JPSR system to report community care-related patient safety events.[61] Once patient safety events are reported, processes are used to mitigate recurring events, including evaluation of contributing factors, associated actions, and outcome measures.[62]

VHA guidance also notes that the facility PSM must give feedback to reporters.[63] An IVC patient safety and quality training document indicates that PSMs can contact a TPA after submitting a

[59] Contract No. 36c79119D0005 issued by VA with Optum Public Sector Solutions, Inc., December 28, 2018. Of note, Optum provided the OIG with all requested documentation related to Optum's accreditation and credentialing of the surgeon without requiring a subpoena. The scope of OIG's authority to receive and review documents to which VA has access is very broad and includes documents that are protected under federal and state privacy and confidentiality laws.

[60] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022. The OIG considers the terms patient safety incidents, events, and concerns interchangeable. This report refers to patient safety-related incidents as patient safety events.

[61] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[62] VHA Handbook 1050.01; *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in effect at the time of the review until it was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The two policies contain similar language related to processes used to mitigate recurring events.

[63] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021. This guidance was in effect at the time of the review until it was replaced by VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.The two guidebooks contain similar language related to reporter feedback.

potential quality issue (PQI) to confirm that the TPA addressed the patient safety event and inquire to learn whether a PQI is "open, ongoing, or closed." [64]

Upon review of facility JPSR training materials, the OIG found guidance for completing a patient safety event report in JPSR for events that occurred at a VA facility but did not find that reporting community care patient safety events was addressed.

During interviews, the PSM told the OIG that JPSR is the approved reporting system for VA, and patient safety staff train facility staff on the use of the JPSR system. However, the nurse practitioner and a primary care leader reported being unaware of the recommendation to report patient safety events related to care provided in the community through the JPSR system.

The nurse practitioner told the OIG about the lack of care coordination a patient received in the community. The nurse practitioner also reported that the concern was shared with a primary care leader. When the OIG asked the nurse practitioner if the concern had been reported as a JPSR event, the nurse practitioner explained completing a JPSR event report for a community care concern had never been discussed and that JPSR event reports had only historically been done for issues that occurred within VA.

Further, a primary care leader told the OIG that JPSR system training focused on reporting patient safety events for care provided within VA, not community care.

When asked about TPA follow-up in response to submitted PQIs, the PSM explained that no information was shared regarding the outcome of the TPA's investigation of a patient safety event. The PSM elaborated "I wish we [patient safety managers] would get information back . . .[patient safety managers] can't do anything from the patient safety perspective." The PSM was unaware of being able to obtain the status of a PQI investigation from a TPA. Therefore, the PSM did not acquire PQI updates to provide to staff who reported patient safety events.

The community care physician and the surgical provider told the OIG of being frustrated with the lack of feedback after reporting a JPSR event related to community care events. The community care physician told the OIG of times when a JPSR event report was completed for community care, however, the event report "vanished" and the PQI "goes to the sky somewhere." The community care physician elaborated that feedback is not received [from the TPA]. The community care physician added that the lack of feedback "doesn't really make me wanna [*sic*] do another one . . . like, why are we doing this [JPSR event] report?" The

"Patient Safety and Quality (PS/Q) Overview and the Peer Review Process" (PowerPoint),VHA IVC, accessed July 18, 2022, https:dvagov.sharepoint.com. (This website is not publicly accessible.); VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022. A PQI is a potential quality or patient safety concern related to community care reported to the TPA.

community care physician concluded, "it's frustrating to find these [events] and then [the event] just goes into a black hole."

The surgical provider told the OIG,

> I never know what happens after I fill out [a community care JPSR event report] because no one gives me any feedback. I have . . . put one or two in and then I never heard anything or knew anything would be done, so I just said I'm not filling [a JPSR event report] out all the time because I don't know if there are any consequences to what I'm doing.

The OIG concluded that the facility's patient safety training did not include completing JPSR event reports for patient safety events in the community. The OIG also found that JPSR event reporters did not receive feedback on reported events and that the PSM was unaware of the ability to contact the TPA for updates on the status of PQIs. As a result, some staff were inclined not to report community care patient safety events. Failure to report community care patient safety events could inhibit process improvement and have a negative effect on patient safety.

Conclusion

Multiple failures by both Optum and IVC undermined the CCN credentialing and oversight processes, and ultimately allowed the subject surgeon to practice in the community care program.

The OIG found deficiencies in Optum's credentialing of the surgeon related to NCQA credentialing accreditation standards and Optum's credentialing process. Specifically, Optum failed to address concerns identified by the certified verification organization in the surgeon's 2018 credentialing file. Due to lack of documentation, the OIG was unable to determine Optum's rationale for approving the surgeon's credentialing.

The VA TPA contract does not define *involuntary relinquishment*, *loss of a medical license*, or *termination for cause*. Further, the VA TPA contract does not differentiate between disciplinary and non-disciplinary license relinquishments or address whether a provider must be excluded from the CCN if the provider voluntarily relinquishes a medical license after notification of an investigation or a potential license termination for cause. This lack of clarity in the contract may have contributed to Optum's determination that the surgeon was eligible to participate in the CCN.

IVC staff responsible for oversight of the CCN provider credentialing failed to thoroughly review the surgeon's credentialing file and identify inconsistencies that should have impacted credentialing decisions after learning of GAO concerns and the OIG's inspection focusing on the surgeon. The current IVC CCN credentialing supervisor requested a review of the surgeon's credentialing file in June 2022, five months after the GAO requested IVC conduct a review of providers who were potentially ineligible to provide community care to veterans. Later that

month, an IVC health system specialist reviewed the surgeon's credentialing file. In addition, IVC provided the OIG with evidence of primary source verification of the surgeon's medical licenses approximately 12 months after the GAO requested review of identified providers, including the surgeon's eligibility to participate in the CCN. Ultimately, IVC did not identify any negative findings for the surgeon. The OIG is concerned that IVC has missed similar information for other providers on the GAO list that is detailed in this report.

The OIG determined that the Optum vice president of provider network and credentialing's viewpoint regarding providing IVC with documentation related to the provider's credentialing and IVC's understanding of the ability to obtain NPDB reports from Optum were inaccurate. According to the Privacy Act regulation, Optum was allowed to disclose NPDB records to IVC, a federal agency requesting data concerning a healthcare provider for the purpose of evaluation related to the delivery of health care. Without the complete NPDB reports, IVC was unaware of the surgeon's Florida medical license action at the time of receipt of the credentialing file from Optum.

The facility's patient safety training did not include completing JPSR event reports for patient safety events in the community. Facility staff who reported community care patient safety events in the JPSR system did not receive feedback on reported events. Additionally, the PSM was unaware of the ability to contact the TPA for updates on the status of a PQI. As a result of these failures, some staff were inclined not to report community care patient safety events. Failure to report community care patient safety events could inhibit process improvement and have a negative effect on patient safety.

Recommendations 1–8

1. The Under Secretary for Health initiates a review of the surgeon's eligibility to participate in VA's Community Care Network given Optum's lack of documentation of their review of the surgeon's credentialing file and takes action, as indicated.
2. The Under Secretary for Health reviews community care network contracts and considers modifying contracts to ensure that voluntary relinquishments and surrenders of licenses for disciplinary reasons are disqualifying for participation in VA's Community Care Network consistent with the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act.
3. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures Optum's sufficient review and discussion of community care network providers' adverse credentialing files and monitors for compliance.
4. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures that Optum documents community care network provider credentialing decisions as required and monitors for compliance.

5. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures that Optum complies with community care contract provisions to provide Integrated Veteran Care with accreditation and credentialing documentation in accordance with federal privacy laws and VA's community care network contract.
6. The Office of Integrated Veteran Care Executive Director, Integrated External Networks verifies that providers identified on the 2021 Government Accountability Office list are eligible to provide care in the VA Community Care Network.
7. The VA Heartland Network Director initiates a review of all community care provided by the surgeon.
8. The VA Marion Health Care System Director ensures primary care and patient safety staff receive education on their responsibility for Joint Patient Safety Reporting and follow-up of patient safety events related to community care, and monitors compliance with patient safety event reporting and follow-up.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 20, 2023

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration (VHA) Oversight Failures (VIEWS 10870457)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report regarding community care network credentialing processes. VHA concurs with recommendations 1-6 and provides an action plan in the attachment.
2. Implementation of the Cleland Dole Act 144 and subsequent implementation of the National Provider Data Bank Continuous Query provider enrollment will greatly enhance the provider monitoring process by the contractors. It will facilitate an update within 24 hours from when an individual provider in the network has a change in status.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

Office of the Under Secretary for Health

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures

(OIG 2022-02294-HI-1260)

Recommendation 1. The Under Secretary for Health initiates a review of the surgeon's eligibility to participate in VA's Community Care Network given Optum's lack of documentation of their review of the surgeon's credentialing file and takes action, as indicated.

VHA Comments: Concur. The Office of Integrated Veterans Care (IVC) reviewed the surgeon's eligibility to participate in VA's Community Care Network (CCN) and took appropriate action. IVC's removal of the provider from the CCN prevents VA from referring Veterans to this community provider. IVC will confirm that Optum has taken all steps to eliminate this provider from its system.

Status: In Progress Target Completion Date: November 2023

Recommendation 2. The Under Secretary for Health reviews community care network contracts and considers modifying contracts to ensure that voluntary relinquishments and surrenders of licenses for disciplinary reasons are disqualifying for participation in VA's Community Care Network consistent with the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act.

VHA Comments: Concur. There is existing language in the contract related to provider license terminations. In Section 3.71 the contract states, "If a provider is or has been licensed in more than one state, the Contractor must always confirm that the provider certifies that none of those states has terminated such license for cause and that the provider has not involuntarily relinquished such license in any of those states after being notified in writing by that state of potential termination for cause." OIG stated Optum had differing interpretations of the term "voluntary relinquishment" being a surrender. IVC will review current contracts to ensure the language is suitable and that there are consistent interpretations between all parties. In addition, future implementation of the Cleland Dole Act will require provider enrollment into National Practitioner Data Bank Continuous Query (NPDBCQ), where all actions taken on a provider's license will be reported to the contractor upon entry into the databank. This requirement will strengthen the monitoring of provider license issues.

Status: In Progress Target Completion Date: March 2024

Recommendation 3. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures Optum's sufficient review and discussion

of community care network providers' adverse credentialing files and monitors for compliance.

VHA Comments: Concur. IVC agrees that ensuring the Third-Party Administrators (TPA) are maintaining sufficient reviews and credentialing of providers is an important function of providing reputable Veteran care. Currently, Optum updates IVC regarding the status of their providers, and, in turn, IVC ensures updates are made to the Provider Payment Management System (PPMS). IVC credentialing completes monthly audits of providers to confirm active licenses, non-inclusion of the List of Excluded Individuals and Entities list and Drug Enforcement Agency confirmation as applicable. Optum continues to update the IVC team regarding provider status, and to ensure compliance, IVC will continue to perform the monthly reviews. In addition, the Cleland Dole Act requires provider enrollment into the NPDBCQ where all actions taken on a provider's license will be reported to the contractor upon entry into the databank. This requirement will strengthen the monitoring of provider license issues. IVC will request and review Optum's credentialing committee meeting agendas and minutes to ensure decisions on providers with adverse findings are within compliance.

Status: In Progress Target Completion Date: March 2024

Recommendation 4. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures that Optum documents community care network provider credentialing decisions as required and monitors for compliance.

VHA Comments: Concur. To ensure that Optum documents community care network provider credentialing decisions as required, all Optum network provider credentialing decisions are documented in VA's PPMS. A provider's status of active or inactive is reported in PPMS. IVC maintains a review of active providers listed in PPMS. These ongoing reviews allow IVC to monitor the TPAs credentialing decisions. IVC will request and review Optum's credentialing committee meeting agendas and minutes to monitor credentialing decisions on providers and ensure compliance.

Status: In Progress Target Completion Date: March 2024

Recommendation 5. The Office of Integrated Veteran Care Executive Director, Integrated External Networks ensures that Optum complies with community care contract provisions to provide Integrated Veteran Care with accreditation and credentialing documentation in accordance with federal privacy laws and VA's community care network contract.

VHA Comments: Concur. IVC will ensure the contractor is held to the standards set forth in the contract when requesting credentialing documentation. The contract language states, "VA reserves the right to perform random reviews of the accreditation, certification, credentialing, privileging/competency measures, and licensing files for the accredited programs and providers within the CCN. The contractor must always provide access to these files within five (5) business days of notification of such review." IVC will consult with contracting to provide contract clarification regarding the statement by the

OIG referencing the Privacy Act. Upon completion and outcome, IVC will provide direction to Optum.

Status: In Progress Target Completion Date: March 2024

Recommendation 6. The Office of Integrated Veteran Care Executive Director, Integrated External Networks verifies that providers identified on the 2021 Government Accountability Office list are eligible to provide care in the VA Community Care Network.

VHA Comments: Concur. IVC will re-evaluate the Government Accountability Office list from 2021. There are 457 active providers identified on the listing and IVC will verify the providers are eligible to provide care in VA CCN. Any ineligible providers will be removed from the PPMS and the contractor's network.

Status: In Progress Target Completion Date: March 2024

Appendix B: VISN 15 Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 12, 2023

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54 HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

Attached is the VISN 15 Heartland Network and facility response to the Healthcare Inspection—Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures.

I concur with the implementation plan. No technical or general comments were provided.

(*Original signed by:*)

Patricia L. Hall, PhD, FACHE
Network Director
VA Heartland Network (VISN 15)

VISN 15 Director Response

Recommendation 7

The VA Heartland Network Director initiates a review of all community care provided by the surgeon.

_X _Concur

____Nonconcur

Target date for completion: June 1, 2024

Director Comments

The reasons for noncompliance were considered when developing the action plan. The Network Director will initiate a review of all community care provided by the surgeon. Actions will include determining all Veterans who were provided care by the surgeon through community care. An audit tool will be developed and completed by a surgeon of similar practice to determine if the standard of care was met. Follow up will be provided for any quality-of-care concerns identified. Progress to completion of the audit will be conveyed to the Quality Council that reports to the Network Director on a quarterly basis. Compliance will be monitored until the audit is complete and all quality-of-care concerns are addressed.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 13, 2023

From: Executive Director, Marion VA Health Care System (657A5/00)

Subj: Healthcare Inspection—Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures

To: Director, VA Heartland Network (10N15)

Attached is the Marion VA Health Care System facility response to the Healthcare Inspection—Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures.

I appreciate the OIG's review of patient safety processes when Veterans are served through VA's Community Care Network. I concur with the OIG's recommendation for the Marion VA Health Care System.

As a rural VA facility, the Marion VA Health Care System relies on community partners to help provide Veterans the high-quality, safe care they need and deserve. Our corrective actions will strengthen our ability to serve Veterans well and prevent patient harm.

(*Original signed by*:)

Zachary M. Sage

Facility Director Response

Recommendation 8

The VA Marion Health Care System Director ensures primary care and patient safety staff receive education on their responsibility for Joint Patient Safety Reporting and follow-up of patient safety events related to community care and monitors compliance with patient safety event reporting and follow-up.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

The reasons for noncompliance were considered when developing the action plan. The Marion VA Health Care System's Local Office of Community Care staff will provide training regarding responsibilities for reporting patient safety concerns related to community care to all current Primary Care Aligned Team (PACT) and patient safety staff. An audit of training documentation will be monitored.

The education will address the VHA's Joint Patient Safety Reporting Guidebook and other applicable guidance regarding responsibilities for reporting patient safety concerns related to community care, monitoring compliance and follow-up action expectations. The goal is to maintain 90% training compliance of all current or newly hired PACT staff. New staff will receive education during new employee orientation. Compliance will be monitored for a minimum of six consecutive months and reported to the Executive Leadership Team through the Quality, Safety, Value, and High Reliability Executive Board.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Chris Iacovetti, BA, RD, Director Stacy DePriest, MSW, LCSW Sheyla Desir, RN, MSN Meredith Magner-Perlin, MPH Carrie Mitchell, MSW, LCSW Robin Moyer, MD Brian Stephens, MA Andrew Waghorn, JD
Other Contributors	Amanda Brown, MSN, RN Lin Clegg, PhD Barbara Mallory-Sampat, JD, MSN Nitin Patel, MPH, BS Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
Office of General Counsel
Director, VA Heartland Network (10N15)
Director, VA Marion Health Care System (657/A5)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
Illinois: Tammy Duckworth, Richard J. Durbin
Indiana: Mike Braun, Todd Young
Kentucky: Mitch McConnell, Rand Paul
US House of Representatives
Illinois: Mike Bost, Nikki Budzinski, Mary Miller
Indiana: Larry Bucshon
Kentucky: James Comer, Brett Guthrie

Pursuant to Pub. L. 117-263, section 5274, non-governmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference. The comments can be found on the report summary page.

OIG reports are available at www.va.gov/oig.