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VETERANS COMMUNITY CARE PROGRAM

VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers

Statement of Seto Bagdoyan, Director,
Forensic Audits and Investigative Service

GAO-22-105831

GAO Highlights

Highlights of GAO-22-105831, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

March 30, 2022

VETERANS COMMUNITY CARE PROGRAM

VA Should Improve Its Ability to Identify Ineligible Health Care Providers

Why GAO Did This Study

Eligible veterans may receive care from community providers through Department of Veterans Affairs' (VA) VCCP when veterans face challenges accessing care at VA medical facilities. VA is responsible for ensuring VCCP providers are qualified and competent to provide safe care to veterans based on the eligibility requirements and restrictions.

This testimony summarizes GAO's December 2021 report on VCCP provider eligibility controls. For that report, GAO interviewed knowledgeable officials and reviewed VHA and contractor standard operating procedures, policies, and guidance. To identify potentially ineligible providers, GAO compared data from VHA's Office of Community Care to data sources related to actions that may exclude providers from participating in the VCCP.

What GAO Recommends

In December 2021, GAO made ten recommendations to VA, including that VA enhance existing controls, consistently implement controls as described in standard operating procedures, and assess the fraud risk of invalid provider address data. While VA reported taking initial steps toward addressing some of these recommendations, the recommendations are not yet implemented. GAO maintains that all ten recommendations should be implemented to help ensure that veterans receive care from qualified providers through this program.

View GAO-22-105831. For more information, contact Seto J. Bagdoyan, (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

GAO found vulnerabilities in the controls used by the Veterans Health Administration (VHA) and its contractors to identify health care providers who are not eligible to participate in the Veterans Community Care Program (VCCP), resulting in the inclusion of potentially ineligible providers.

Examples of Requirements of and Restrictions on Veterans Community Care Program Provider Eligibility

Providers must

Have an active, unrestricted medical license in the state in which services will be provided

Certify that no state has terminated a license, registration, or certification for cause

Providers must not

Be excluded from participation in a federal health care program

Be convicted of a felony or other serious state or federal offense, if the VA determines that participation would be detrimental to veterans or the agency

Source: GAO analysis of Department of Veterans Affairs information. | GAO-22-105831

Of over 800,000 providers assessed, GAO identified approximately 1,600 VCCP providers who were ineligible to work with the federal government, were reported as deceased, or had revoked or suspended medical licenses. For example, GAO identified a provider eligible for referrals in the VHA system but whose medical license had been revoked in 2019. Licensing documents stated that the provider posed a clear and immediate danger to public health and safety.

VHA and its contractors had controls in place to identify such providers. However, the existing controls missed some providers who could have been identified with enhanced controls and more consistent implementation of standard operating procedures. For example, GAO found that VHA did not perform some automated checks on a monthly basis as required by the agency's standard operating procedures.

GAO also identified weaknesses in oversight of provider address data. Some VCCP providers used commercial mail receiving addresses, such as a United Parcel Service (UPS) store, as their only service address. Such addresses could be disguised as business addresses by individuals intending to commit fraud. VHA has not assessed the fraud risk that invalid address data pose to the program.

While the number of potentially ineligible providers GAO identified represents a relatively small fraction of the providers in its analysis, these vulnerabilities put veterans at risk of receiving care from unqualified providers. Additionally, VHA is at risk of fraudulent activity, as some of the providers GAO identified had previous convictions of health-care fraud.

Chairman Pappas, Ranking Member Mann, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Department of Veterans Affairs' (VA) Veterans Community Care Program (VCCP) and VA's efforts to ensure that only eligible providers participate in the program.

The VA's Veterans Health Administration (VHA) operates one of the largest health-care systems in the nation, serving over 6 million veterans annually. VA health care is primarily provided to veterans in VA medical facilities. However, when eligible veterans face challenges accessing health care at a VA facility, they can receive care from community providers through the VCCP.[1] According to VA, the number of veterans who received community care from non-VHA providers increased from approximately 1.1 million in 2014 to 1.8 million in 2020, making the VCCP an important component of the agency's approach to providing care.

It is essential that VA's community care providers participating in the VCCP be appropriately screened, including a review of their medical credentials. VA is responsible for ensuring that providers, both those who work in its medical facilities and those who provide care through its community care programs, such as the VCCP, are qualified and competent to provide safe care to veterans. This includes basing its reviews of provider credentials on, among other things, the eligibility requirements and restrictions defined in the VA MISSION Act of 2018.

My remarks today are primarily based on our report issued in December 2021.[2] Specifically, this testimony discusses the extent to which vulnerabilities in VCCP eligibility controls contributed to potentially ineligible providers participating in the program. This testimony also

[1]VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, 132 Stat. 1393, 1395-1404 (2018).

[2] GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers,* GAO-22-103850 (Washington, D.C.: Dec.17, 2021).

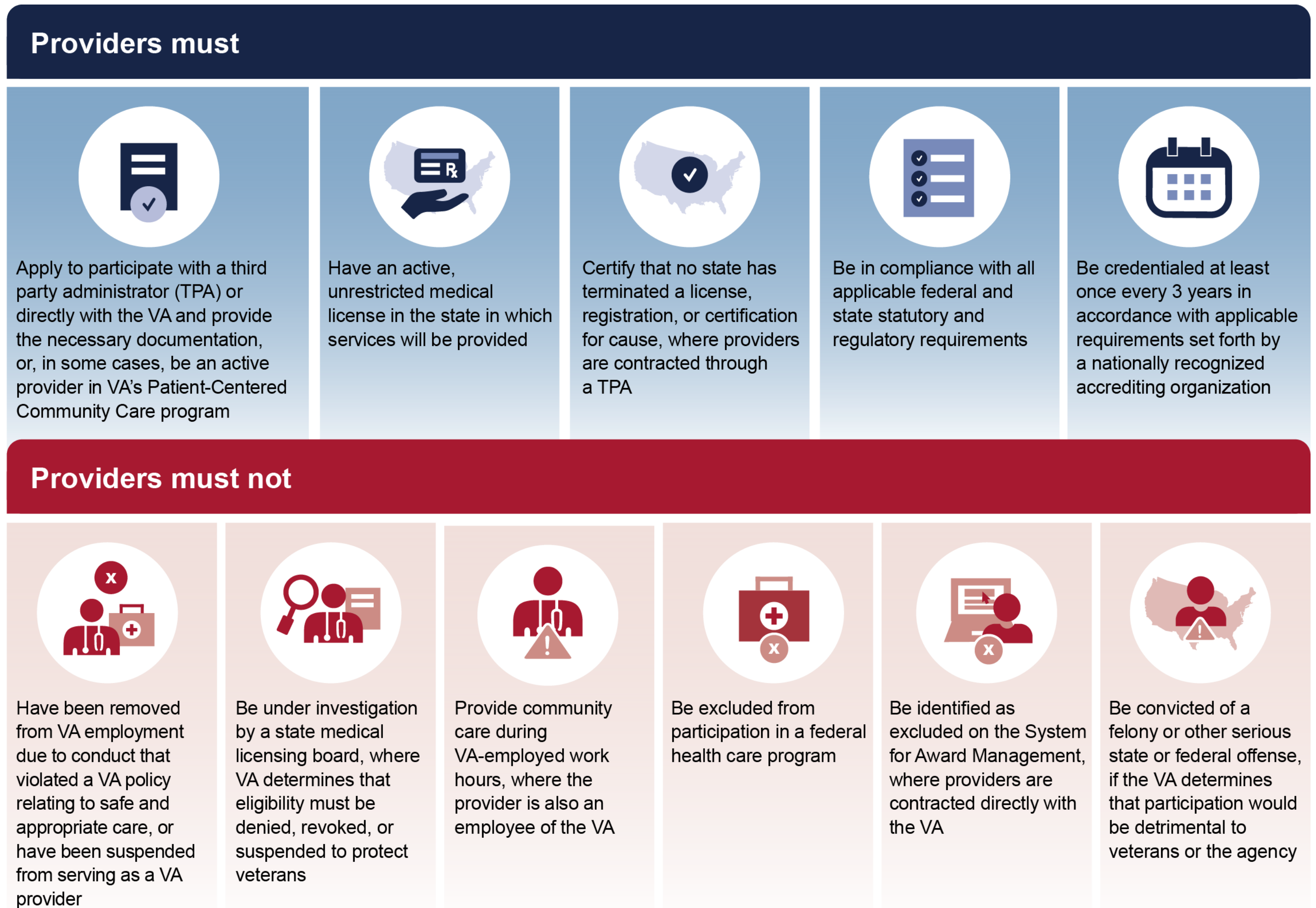
discusses work from our February 2021 report, which also examined VHA's oversight of VCCP providers' credentialing.[3]

VHA contracts with two third-party administrators (TPA) to develop and manage the VCCP's network of providers. These TPAs are responsible for recruiting, building, and managing networks of health care community providers, among other duties. According to VHA officials, as of July 2021, about 1.2 million providers were listed as "active" throughout the network, meaning the providers were eligible to receive patient referrals through the VCCP. Together, VHA and the two TPAs are responsible for screening providers who provide care to veterans through the VCCP.

The VA MISSION Act granted greater authority to VA in determining the eligibility of providers to participate in its community care program. Specifically, the act as implemented by VHA established various provider participation requirements for the VCCP, as illustrated in figure 1.

[3] We have previously reported on VHA's oversight of community care physicians' credentials and made recommendations for improvements to VA requirements for contractor credentialing and monitoring policies. VA generally concurred with our recommendations. See GAO, *Veterans Community Care Program: Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded,* GAO-21-71 (Washington, D.C.: Feb.1, 2021).

Figure 1: Requirements of and Restrictions on Veterans Community Care Program Provider Eligibility

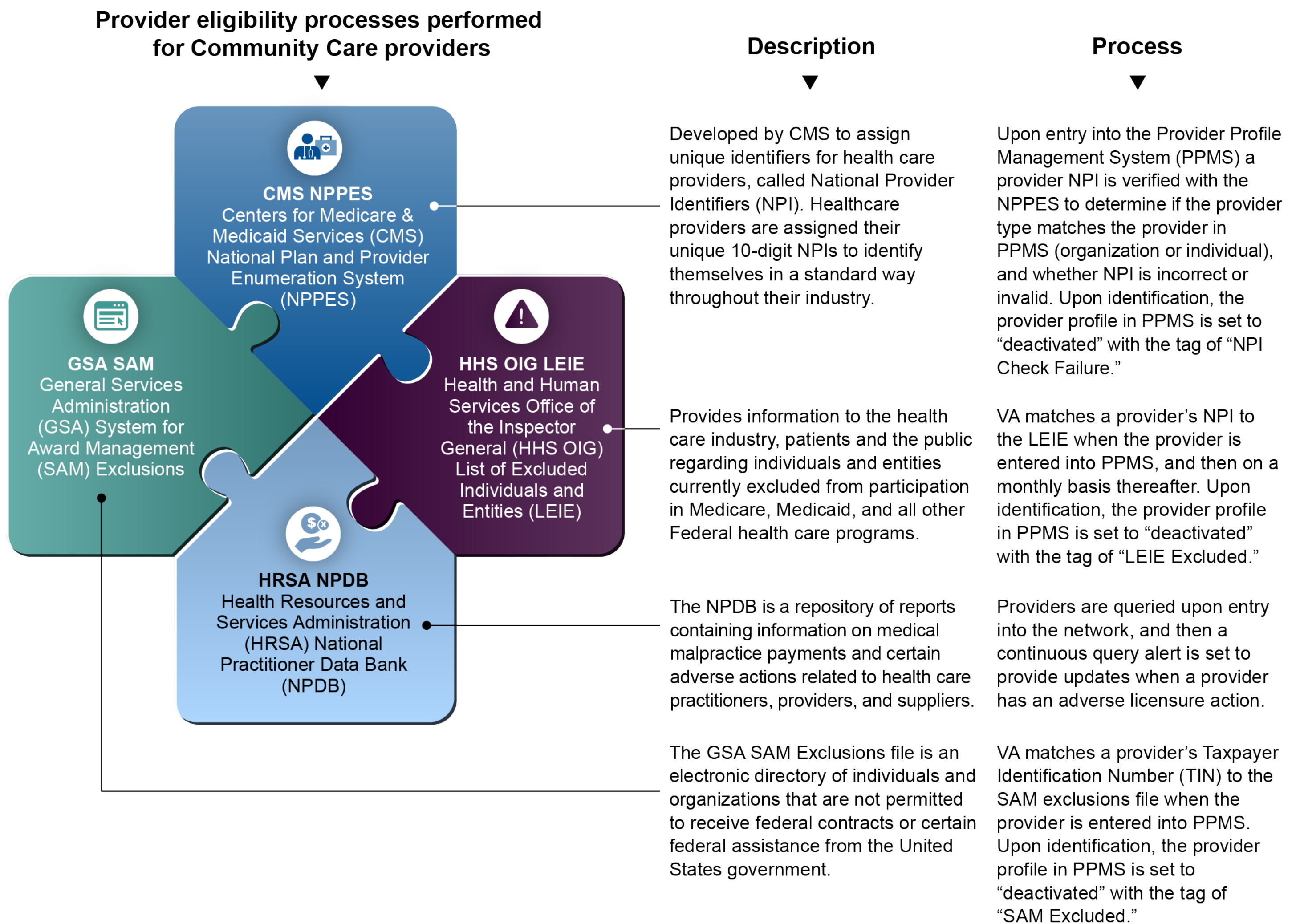


Source: GAO analysis of Department of Veterans Affairs (VA) information. | GAO-22-105831

The VA Office of Community Care and the TPAs use several data sources to identify providers who should be excluded from participating in the VCCP. These data sources document a provider's status in the health-care industry and eligibility to participate in federal programs.

Figure 2 describes the four primary data sources used by VA and the TPAs to screen for ineligible providers and the information each data source contains.

Figure 2. Summary of Exclusionary Data Sources and Oversight Functions



Source: GAO analysis of publically available and federal database information. | GAO-22-105831

To examine VCCP eligibility controls for our December 2021 report, we interviewed knowledgeable officials and reviewed VHA and contractor standard operating procedures, policies, contracts, and guidance focused on VCCP provider eligibility screening controls. Further, we compared data from VHA's Office of Community Care to data sources related to actions that may exclude providers from participating in the VCCP. Specifically, we obtained and analyzed provider data from VHA's Provider Profile Management System (PPMS) – VHA's master database of

community providers – current as of March 2020.[4] We then matched the providers from PPMS to several data sources to identify providers:

- Prohibited from participating in Federally funded health care programs;[5]
- Prohibited from doing business with the federal government;[6]
- With invalid National Provider Identifiers (NPI);[7]
- Reported as deceased;[8]
- Who had adverse actions taken against their provider licenses or certain health care-related judgments and convictions;[9] and
- With invalid addresses.[10]

[4]According to VHA, PPMS was deployed nationally at the end of fiscal year 2018. VHA officials stated that PPMS is the authoritative source for VCCP provider information. Providers are identified by their National Provider Identifier (NPI), which is a unique 10-digit number issued to individual and organizational health-care providers in the United States by the Centers for Medicare and Medicaid Services. PPMS receives and stores information about each provider, such as provider name, and the types of services the provider is authorized to deliver.

[5]This data source is the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities.

[6]This data source is the U.S. General Services Administration System for Award Management Exclusions.

[7]This data source is the monthly HHS National Plan and Provider Enumeration System National Provider Identifier Deactivation file. Providers are identified by their NPI, which is a unique 10-digit number issued to individual and organizational health-care providers in the United States by the Centers for Medicare and Medicaid Services.

[8]This data source is the Social Security Administration Death Master File.

[9]This data source is the U.S. Health Resources and Services Administration National Practitioner Data Bank adverse action report file and the judgement and convictions file.

[10]This data source is the United States Postal Service Address Matching System tool.

We identified some limitations to the data that may yield understated results.[11] Overall, however, we found that the data were generally reliable for our purposes, including matching to data sources to identify indicators of potentially ineligible providers.

To identify case studies, we selected a judgmental sample of 88 health-care providers from the results of matches of providers in PPMS to data sources that would flag potentially ineligible providers. The case studies provide illustrative examples of how the oversight mechanisms may or may not be working as intended.[12]

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[11]First, due to technical issues with PPMS, VA was unable to provide us with a complete list of all VCCP providers in the system. As of September 2021, VHA was still working to address these technical issues. Second, because Social Security Numbers (SSN) are not stored in PPMS and we intended to use SSNs as a matching field in our analysis, we obtained this information for our providers from the NPPES NPI registry maintained by the Centers for Medicare and Medicaid Services (CMS) to facilitate our data matching. We were able to obtain SSNs for about 84 percent of the providers in our PPMS population this way. The NPPES registry may not have a SSN for providers because the NPI is an organization NPI, which would not have an SSN.

[12]Providers in our sample included health-care organizations—such as nursing homes—physicians, nurses, dentists, and physical therapists. For each provider in our sample, we reviewed publically available information, such as information used to obtain an NPI with the NPPES, medical board licensing documentation if applicable, pertinent criminal history information, and VCCP claims data, if available. We also confirmed key case details with VHA and TPA officials. This included obtaining documentation and testimonial evidence to determine whether the VCCP provider oversight controls in place identified the providers in a timely fashion and, if not, why these control mechanisms did not function as designed.

Vulnerabilities in Eligibility Controls Allowed Potentially Ineligible Providers to Participate in VA's Veterans Community Care Program

Vulnerabilities in VHA and TPA provider eligibility controls resulted in potentially ineligible providers participating in the VCCP. While the number of potentially ineligible providers we identified represents a relatively small fraction of the 826,101 providers in our analysis, the vulnerabilities could put veterans at risk of receiving inadequate care and expose VA to the risk of fraud. Among VA's active PPMS providers, we identified:

- 27 providers who appeared on the Department of Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) exclusions list;
- 16 providers who appeared on the U.S. General Services Administration (GSA) System for Award Management (SAM) exclusions file;
- 601 deceased providers listed on the HHS National Plan and Provider Enumeration System (NPPES) monthly NPI deactivation file;
- 216 providers with revoked licenses;
- 796 providers who surrendered their licenses in response to investigation; and
- 37 providers who had a fraud-related judgement or conviction.[13]

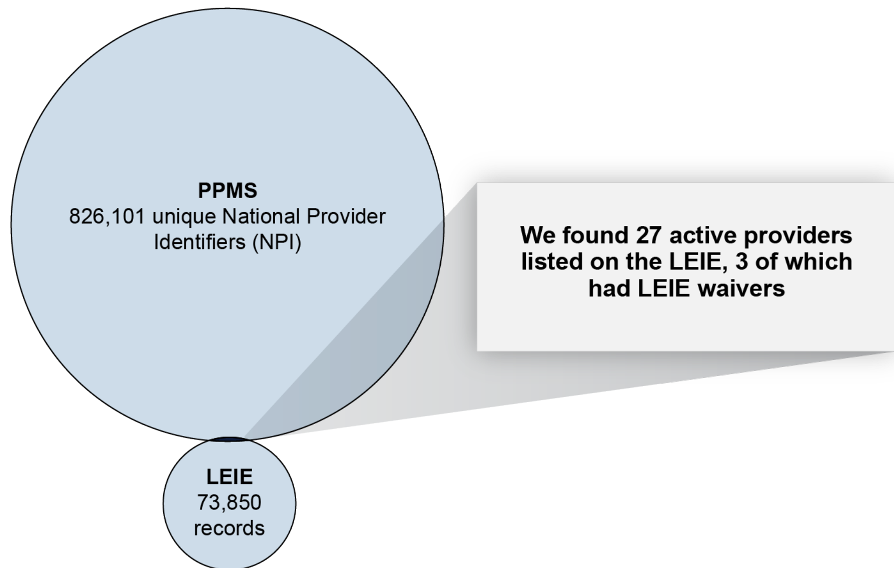
VA Did Not Exclude 27 Providers Who Appeared on the LEIE Exclusions List

Among the potentially ineligible providers who we identified were 27 providers listed on the HHS OIG LEIE.[14] (See figure 3.)

[13]Following the issuance of our report, we referred the potentially ineligible providers we identified to VA for its review and subsequent action, as appropriate.

[14]Three of the 27 had LEIE waivers, which are explained below.

Figure 3 Results of PPMS and HHS OIG LEIE Data Analysis



Source: GAO analysis of Department of Veterans Affairs and HHS OIG LEIE information. | GAO-22-105831

The LEIE is updated and available for public review on a monthly basis. If the VHA and TPA controls functioned as intended, all providers we found should have been identified as excluded within one month of appearing on the LEIE. However, we found that LEIE checks were not performed automatically on a monthly basis as required by VHA Office of Community Care Provider Exclusion Standard Operating Procedures.

Further, VHA may have missed some providers on the LEIE because the agency only used the NPI field when matching data to the LEIE. By contrast, we identified providers by using SSN or Tax Identification Number (TIN) as the matching field, in addition to NPI. We used SSNs to match providers to the LEIE because, among other reasons, the LEIE does not list an NPI for every provider and some providers in PPMS listed

an organizational NPI instead of an individual NPI.[15] Because a provider can apply to NPPES for both individual and organizational NPIs, PPMS could list an organizational NPI for a provider while the LEIE could list that provider's individual NPI. In such a scenario, VA would not identify the provider as a LEIE match if they used only one of the provider's NPIs.

Additionally, VHA officials told us that PPMS did not have the capability of distinguishing the regional eligibility status of providers who were granted LEIE waivers.[16] LEIE waivers permit otherwise ineligible providers on the LEIE to participate in federal health care programs within certain geographic locations or for a specific type of care.[17] VHA told us that providers with waivers are active in all geographic areas by default, which means that schedulers are unable to determine whether the provider meets the parameters set forth in the waiver.

We recommended that VA use multiple variables, including SSN, when matching to the LEIE. We also recommended that the VHA Office of Community Care identify and implement a process to inform schedulers of specific LEIE waiver specifications. VA concurred in principle with these recommendations but stopped short of agreeing to use SSN as a matching field. VA indicated that it would implement an alternate solution to address LEIE waivers but has not yet provided evidence of fully implementing this solution.

VA Did Not Exclude 16 Providers Who Appeared on the SAM Exclusions File

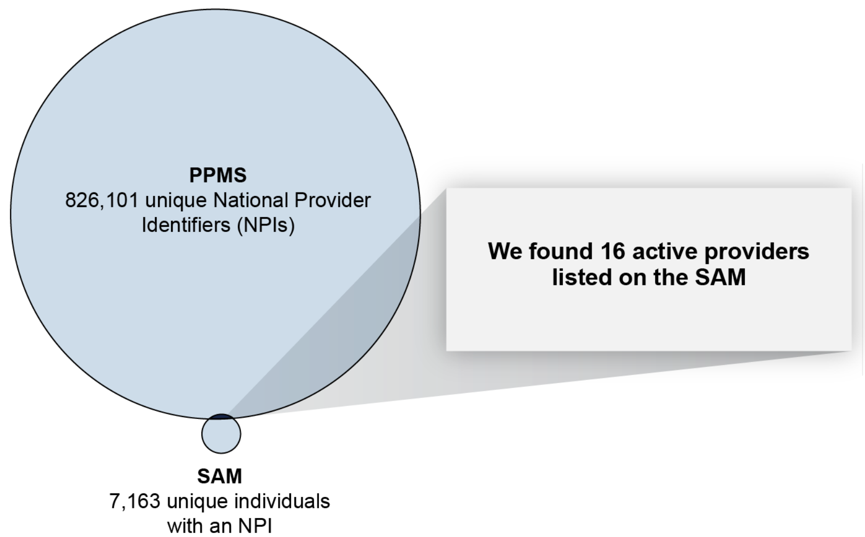
Among the potentially ineligible providers we identified were 16 providers included on the SAM exclusions file. (See figure 4.)

[15]NPPES has two types of provider NPI, one for individual providers registering in the system and one for organizational providers, generally comprised of staff members with their own individual NPIs. In the case of organizational NPIs, the profile on NPPES will list an Authorized Official who is the representing individual of that organization.

[16]In some cases, providers with NPIs on the LEIE list are granted waivers by the HHS OIG to participate in federal health care programs in specific geographic areas or subject to other limitations. Waivers are only granted if providers offer a unique and necessary specialty for a region and if the loss of the provider would cause harm to the care available in the area. The waiver allows the provider to operate in the geographic area (select counties, state, or territory) where there services are required and they are not allowed to provide service under a federal health care program outside of the selected area.

[17]As of August 2021, HHS OIG had waivers for 10 providers in total. Three of those providers were in the VCCP.

Figure 4: Results of PPMS and GSA SAM Data Analysis



Source: GAO analysis of Department of Veterans Affairs and GSA information. | GAO-22-105831

VHA Office of Community Care used TINs, which were not consistently populated in PPMS, to match against the SAM exclusions file. We identified these 16 providers by matching on NPI, which all providers in PPMS were required to furnish. VHA standard operating procedures do not require use of additional available identifiers it has in PPMS, such as NPI. Further, VHA Office of Community Care officials stated that VHA does not require or instruct the TPAs how to match against the SAM exclusions file.

While there are limitations to the sole use of NPI as a match field, as noted above, using multiple match fields to screen for providers could enhance existing screening controls. VA risks overlooking ineligible providers who should be prohibited from participating in the VCCP by limiting screening to the TIN match field. Updated documentation, which VHA is in the process of implementing, shows that PPMS will only check SAM using NPI. This process, when employed, will still limit the fields with which providers are checked against SAM.

VHA officials also stated that technical challenges prevented them from implementing procedures designed to use the SAM Exclusions file to screen VCCP providers on a monthly basis. Specifically, VHA officials stated that the number of providers to be checked was too large for the available system to handle.

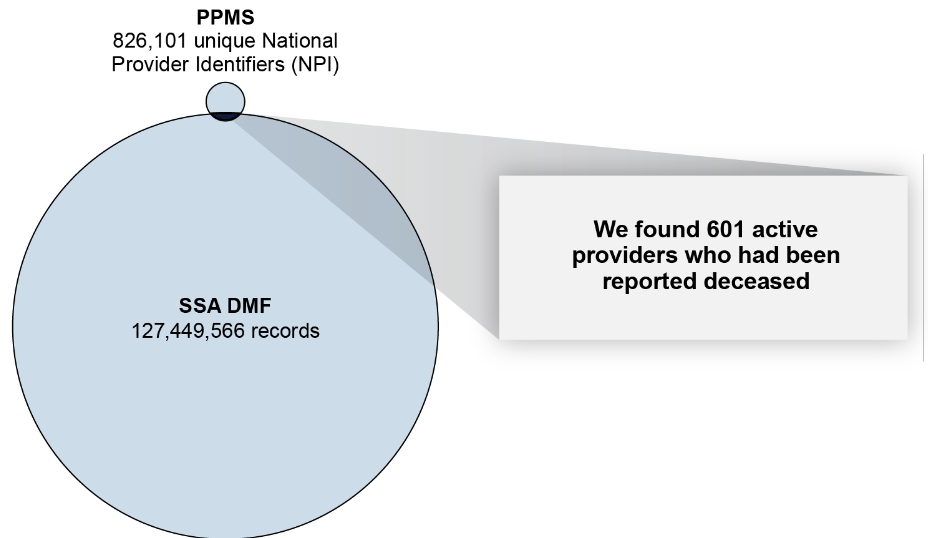
We recommended that VA revise its Provider Exclusion Standard Operating Procedures to require automated matching of providers in PPMS to the SAM Exclusions file using both TIN and NPI as identifiers. VA concurred in principle but said the agency would not match providers using NPI due to concerns of excluding false-positive identifications. We contend that flagging false-positives for review does not automatically lead to excluding providers in PPMS. Further, it is better to flag a false-positive for review than it is to overlook ineligible providers altogether.

We also recommended that VA work with GSA to resolve the technical challenge preventing the agency from routinely matching providers to the SAM Exclusions file. VA concurred with this recommendation and stated that it was implemented. In September 2021, VHA officials provided technical plans intended to resolve the issue, but have not yet shown that the plans were implemented.

VA Did Not Exclude 601 Deceased Providers Listed on the NPPES Monthly Deactivation File

We identified 1,069 deceased providers in PPMS as of March 2020, of which 601 were active and, therefore, available for referrals. (See figure 5.)

Figure 5: Results of PPMS and Social Security Administration Death Master File Data Analysis



Source: GAO analysis of Department of Veterans Affairs and SSA information. | GAO-22-105831

We found that most deceased providers had deactivated NPIs in NPPES. For example, of the 1,069 total deceased providers we identified in PPMS, 1,061 of them had deactivated NPIs as of January 2021 when we checked their records. Further, of the 601 active deceased providers we identified above, 594 had deactivated NPIs as of January 2021.

Given that the NPPES Monthly Deactivation file deactivates the NPIs of most deceased providers, had VHA and the TPAs effectively screened community providers using the NPPES Monthly Deactivation file they could have identified and deactivated deceased providers who remained active in PPMS.

Although VHA standard operating procedures stated and VHA Office of Community Care officials confirmed that the NPPES validation matches are implemented as intended, the results of our analysis suggest this is not the case. Specifically, we identified deceased providers who remained active in PPMS months after their NPIs were deactivated by NPPES.

We recommended that VA conduct automated matching to NPPES, as well as LEIE and SAM, in accordance with the monthly timeline outlined in its Provider Exclusion Standard Operating Procedures. VA concurred with this recommendation and planned to fully implement it in December 2021. VA has not yet provided documentation that it has completed this action.

TPAs Did Not Exclude All Providers with Revoked Licenses, Involuntarily Surrendered Licenses, or Fraud-Related Judgments or Convictions

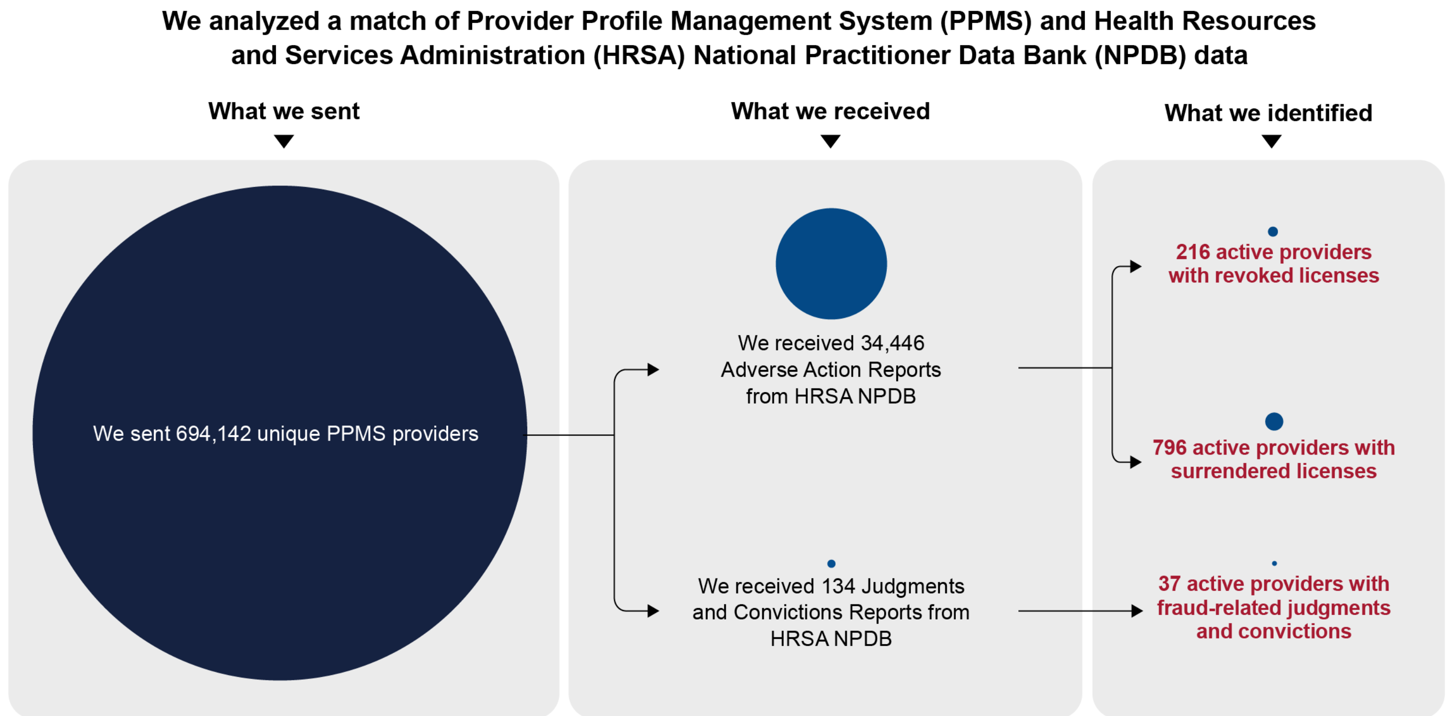
As shown in figure 6, we identified providers with revoked or surrendered medical licenses who were listed as active in PPMS as of March 2020, including:

- 216 providers with revoked licenses in the U.S. Health Resources and Services Administration (HRSA) National Practitioner Data Bank (NPDB) adverse action file;[18]
- 796 providers who had involuntary surrendered their licenses in the NPDB adverse action file;[19] and
- 37 providers who had a fraud-related judgement or conviction as of March 2021 in the NPDB judgments and convictions file.

[18]We identified 239 revoked licenses that had not been reinstated, indicating that some providers had more than one revoked state medical license.

[19]We identified 886 surrendered licenses that had not been reinstated, indicating that some providers had more than one surrendered state medical license. We define involuntary surrenders 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 health care practitioner, health care entity, provider, or supplier to surrender the license or certification (including certification agreements or contracts for participation in federal or state health care programs)." The definition also includes those instances where a health care practitioner, health care entity, provider, or supplier voluntarily surrenders a license or certification (including program participation agreements or contracts) 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.

Figure 6: Results of PPMS and HRSA NPDB Data Analysis



Source: GAO analysis of Department of Veterans Affairs and HRSA information | GAO-22-105831

The VA MISSION Act prohibits providers from participating in the VCCP if they have lost a medical license, for instance, as a result of revocation or termination for either cause or concerns of poor quality of care. The NPDB contains information on health-care providers who have been disciplined by a state licensing board, professional society, or health-care entity; have been named in a health care-related judgment or criminal conviction; or have been identified in some other adverse action.

In this regard, we identified an instance wherein a medical provider was available for referrals despite having his medical license suspended by a state medical board in April 2019 and subsequently revoked in July 2019. The board documents state that the provider posed a clear and immediate danger to public health and safety. The Drug Enforcement Administration also revoked the provider's registration. VHA officials stated that this provider was available for service referrals in PPMS from February 2019 through April 2019, and September 2019 through April 2021. This means the provider was eligible for patient referrals in PPMS even though the medical board revoked his license due to safety issues.

In February 2021, we found that when credentialing providers, TPAs may query the NPDB to identify actions that disqualify providers from participating in the Community Care Network.[20] However, TPAs were not contractually required to continuously monitor providers' licensure statuses. Specifically, at the time our report was issued one of the TPA's policies for reviewing license sanctions did not require verification in states other than where the provider furnished community care services. Since then, this TPA updated its policy to require the use of the NPDB for all providers during initial credentialing and recredentialing. In February 2021, we found that neither TPA required a continuous monitoring process of providers' licensure sanctions in all states for all providers.

We made two recommendations in our February 2021 report to address these issues. First, we recommended that VA amend TPA's credentialing policies to ensure that providers who have violated the requirements of medical licenses that resulted in the loss of those medical licenses in any state are excluded from providing care to veterans through the VCCP. Second, we recommended that VA's TPAs develop and implement a process for continuous monitoring of the eligibility requirements in section 108 of the VA MISSION Act, such as by using the NPDB's continuous query function. VHA implemented the first recommendation in October 2021 and is in the process of implementing the second recommendation. Implementation of both of these recommendations should improve provider licensure oversight.

VHA's Address Verification Processes Did Not Detect Some Indicators of Potential Fraud

Similar to the vulnerabilities of eligibility controls described above, VHA's address verification procedures are not designed to identify indicators of potential fraud. We identified 66 providers whose only practice addresses were commercial mail receiving agencies (CMRA), such as a United Parcel Service (UPS) store, and did not meet the requirements outlined in VCCP contracts. Such addresses could be disguised as business addresses by individuals intending to commit fraud.

VHA requires all VCCP providers to list a physical location where services are provided to veterans as the providers' primary practice location in PPMS. However, VHA did not have specific requirements or guidance detailing how practice locations should be verified and recorded in PPMS.

[20] GAO-21-71.

Further, TPAs were not required to put in a location unit number, when applicable.[21]

Additionally, VHA did not have a means for verifying that providers provided care at the addresses from which they claimed to work and VHA experienced several challenges in recording address data. For example, one VHA Office of Community Care official stated that there were rollout, personnel, and technology issues when transferring data from one TPA to PPMS, resulting in missing or incorrect data for many of the providers in the Community Care Network. VHA initially used a standard software interface to validate provider addresses in PPMS. However, VHA realized that the validation software was incompatible with one of the TPA's provider databases.

In September 2020, we found that schedulers at VA medical centers had difficulties scheduling VCCP appointments because of issues with the quality of provider address data.[22] We also found that providers sometimes did not know they were in the Community Care Network and that TPAs did not update providers' addresses in PPMS after providers moved locations. We also found that VA and the TPA were working to address these issues.

We found in December 2021 that VA no longer performs address validation of provider addresses. Instead, as VHA Office of Community Care officials explained, VA relies on an automated address confidence system that assists schedulers in selecting care site locations. This software program categorizes the accuracy of provider addresses to help schedulers determine whether they should send a veteran to a specific location for an appointment. However, the system does not account for outdated provider location information or otherwise confirm whether the provider is at a specific location. VHA officials stated that outdated or unreliable provider addresses are common industry-wide and requiring TPAs to verify each provider practice location would be overly burdensome.

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[21]VHA officials stated that Home Health Agency Veterans Care Agreements (VCA) were only required to enter city and state. However, in July 2021, VHA officials stated that all community care providers were required to have a full address. For these VCAs missing full addresses VA staff have been instructed to complete the addresses.

[22]GAO, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care,* GAO-20-643. (Washington, D.C.: Sept. 28, 2020).

VHA officials told us that VA medical center scheduling staff or veterans have the ability to confirm providers' practice locations when scheduling appointments. VHA officials said that when an error with provider information was identified by a scheduler, such as with an outdated or incorrect address, it was the responsibility of the scheduler to work with the TPA to correct the information.

Federal internal control standards call for managers to identify, analyze, and respond to risks.[23] Furthermore, GAO's Fraud Risk Framework emphasizes risk-based preventive activities that are based on a comprehensive, documented risk assessment that identifies risks, assesses them, and develops a strategy to address analyzed risks, including periodic assessments to evaluate continuing effectiveness of the risk response.[24] According to VHA Office of Community Care officials, VHA has not conducted such a risk assessment, which would better position it to design and implement risk-based preventive and other controls to manage these risks.

We made five recommendations that VA conduct and document such risk assessments related to providers' addresses. VA concurred with these recommendations and plans to implement them in 2022. VA is expected to submit a written statement of actions taken on all ten of the recommendations in our December 2021 report by July 2022.

In closing, the vulnerabilities we identified potentially put veterans at risk of receiving care from unqualified providers. Additionally, VHA is at risk of fraudulent activity, as some of the providers we identified had previous convictions of health-care fraud. VA has an opportunity to address these limitations as it continues to refine the program's controls, policies, and procedures.

Chairman Pappas, Ranking Member Mann, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

[23]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

[24]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 28, 2015).

GAO Contact and Staff Acknowledgments

If you or staff have any questions about this testimony, please contact Seto J. Bagdoyan, Director, at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Dean Campbell (Assistant Director), James Ashley, Priyanka Sethi Bansal, Emily Binek, Julia DiPonio, Kristina Hammon, Kelly Husted, Barbara Lewis, Emily Loriso, Marcia Mann, Brittaini Maul, Maria McMullen, Eve Nealon, Sabrina Streagle, Ashni Verma, and Erin Villas.

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