United States Government Accountability Office

Report to Congressional Requesters

December 2021

# VETERANS COMMUNITY CARE PROGRAM

# VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers

**Revised March 11, 2022 to include page four of VA's response to GAO's recommendations.**

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GAO-22-103850

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# Highlights

Highlights of GAO-22-103850, a report to congressional requesters

December 2021

# VETERANS COMMUNITY CARE PROGRAM

## VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers

## Why GAO Did This Study

The VHA allows eligible veterans to receive care from community providers through VA's VCCP when veterans face challenges accessing care at VA medical facilities. VHA is responsible for ensuring VCCP providers are qualified and competent to provide safe care to veterans based on the eligibility requirements and restrictions.

GAO was asked to examine the extent to which vulnerabilities in VCCP provider eligibility controls contributed to potentially ineligible providers participating in the program.

GAO reviewed VHA and contractor standard operating procedures, policies, and guidance. GAO also interviewed knowledgeable officials. 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

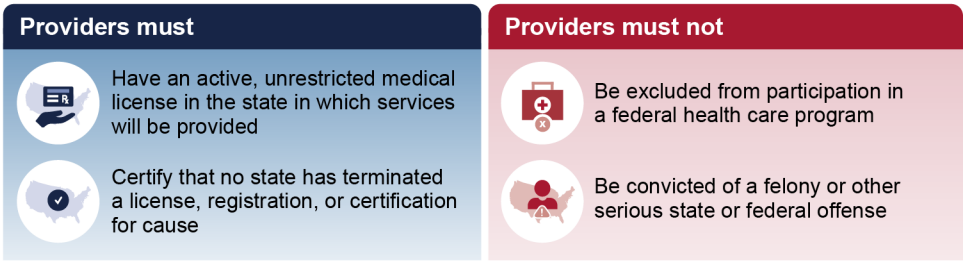
GAO is making ten recommendations to VA, including that VA enhance existing controls, consistently implement controls as described in standard operating procedures, and assess the fraud risk of invalid provider address data. VA generally agreed with GAO's ten recommendations.

View GAO-22-103850. For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov or Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

## What GAO Found

GAO found vulnerabilities in the controls used by the Department of Veterans Affairs' (VA) 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**




Source: GAO analysis of Department of Veterans Affairs information. | GAO-22-103850

Of over 800,000 providers assessed, GAO identified approximately 1,600 VCCP providers who were deceased, were ineligible to work with the federal government, or had revoked or suspended medical licenses. 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 the following:

- One provider had an expired nursing license in April 2016 and was arrested for assault in October 2018. This provider was excluded from working in federally funded health care programs. The provider was convicted of patient abuse and neglect in July 2019. The provider entered the VCCP in November 2019. VHA officials stated that this provider was uploaded into the system in error.
- One provider was eligible for referrals in the VHA system, but his medical license had been revoked in 2019. Licensing documents stated that the provider posed a clear and immediate danger to public health and safety.

GAO also identified weaknesses in oversight of provider address data. Some VCCP providers used commercial mail receiving addresses as their only service address. Such addresses have been disguised as business addresses in the past by individuals intending to commit fraud. VHA has not assessed the fraud risk that invalid address data pose to the program.

These vulnerabilities potentially 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. VA has an opportunity to address these limitations as it continues to refine the controls, policies, and procedures for this 2-year old program.

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## Abbreviations

| | |
|---|---|
| CMRA | commercial mail receiving agency |
| CMS | Centers for Medicare and Medicaid Services |
| DMF | Death Master File |
| GSA | General Services Administration |
| HHS | U.S. Department of Health and Human Services |
| HRSA | U.S. Health Resources and Services Administration |
| LEIE | List of Excluded Individuals/Entities |
| NPDB | National Practitioner Data Bank |
| NPI | National Provider Identifier |
| NPPES | National Plan and Provider Enumeration System |
| OIG | Office of Inspector General |
| Optum | Optum Public Sector Solutions, Inc. |
| PPMS | Provider Profile Management System |
| SAM | System for Award Management |
| SORN | System of Records Notice |
| SSA | Social Security Administration |
| SSN | Social Security Number |
| TIN | Taxpayer Identification Number |
| TriWest | TriWest Healthcare Alliance Corp. |
| TPA | third-party administrator |
| USPS | United States Postal Service |
| VA | Department of Veterans Affairs |
| VCA | Veterans Care Agreement |
| VCCP | Veterans Community Care Program |
| VHA | Veterans Health Administration |

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**441 G St. N.W.**
**Washington, DC 20548**

December 17, 2021

The Honorable Jack Bergman
Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Chris Pappas
Chairman
The Honorable Tracey Mann
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health-care systems in the nation, serving over 6 million veterans annually, with over 9 million veterans enrolled. Veterans receive most of their care in VA medical facilities. However, when eligible veterans face challenges accessing health care at a VA facility, VHA allows them to receive care from community providers through VA's Veterans Community Care Program (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. Accordingly, it is essential that VA's community care providers are 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, are qualified and competent to provide safe care to veterans based on, among other things, the eligibility requirements and restrictions defined in the VA MISSION Act of 2018. VHA contracts with two third-party administrators (TPA) to develop and manage the VCCP's Community Care Network. Together, VHA and the two TPAs are responsible for screening VCCP providers.

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

We have previously identified conditions that hindered VA's ability to deliver safe and effective care to veterans.

- In February 2021, we found that the VA and TPA oversight processes may not consistently exclude ineligible community providers, creating a risk that veterans may receive care from ineligible providers.[2]
- In February 2019, we identified conditions in which oversight of VHA providers was inconsistent, in that VHA facilities did not uniformly adhere to policies regarding providers with adverse actions licensure reports.[3]
- In November 2017, we identified instances in which providers who were removed from employment at VA medical centers for quality of care issues went on to provide care to veterans through VA's previous community care program.[4]
- In September 2016, we reported that VHA lacked a comprehensive strategy for overseeing its contractors' processes for the verification of providers' credentials.[5]

You asked us to assess the extent to which ineligible providers may be providing care to veterans through the community care program. In this report, we examine the extent to which vulnerabilities in VCCP eligibility controls contributed to potentially ineligible providers participating in the program.

To examine VCCP eligibility controls, we reviewed VHA standard operating procedures, policies, and guidance focused on VCCP provider eligibility screening controls. We interviewed knowledgeable VHA officials about how these controls were implemented. We also reviewed VHA

[2]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).

[3]GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care,* GAO-19-6 (Washington, D.C.: Feb. 28, 2019).

[4]GAO*, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns,* GAO-18-63 (Washington, D.C.: Nov. 15, 2017).

[5]GAO, *Veterans' Health Care: Improved Oversight of Community Care Physician's Credentials Needed,* GAO-16-795 (Washington, D.C.: Sept. 19, 2016).

contracts with the two TPAs to identify any provider oversight controls, and key guidance VHA provided in the contracts regarding TPAs' oversight of VCCP providers. Further, we interviewed knowledgeable officials with each TPA about their VCCP provider oversight processes and reviewed pertinent TPA policies and procedures.

As part of this work, 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, which includes Community Care Network providers, Veterans Care Agreement (VCA) providers who contract directly with individual VA medical centers to provide community care, and providers still participating from previous VA community care programs. The data in PPMS were current as of March 2020, the most up-to-date data available at the time of our review.[6] We then matched the providers from PPMS to the

- Department of Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), a database of individuals and entities prohibited from participating in federally funded health care programs;
- U.S. General Services Administration (GSA) System for Award Management (SAM) Exclusions file, a database of all entities prohibited from doing business with the federal government;
- HHS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) deactivation file, a monthly dataset containing NPIs that are no longer valid;
- Social Security Administration (SSA) Death Master File, a database containing records of death that have been reported to SSA;
- U.S. Health Resources and Services Administration (HRSA) National Practitioner Data Bank (NPDB) adverse action and judgment or conviction report files, which include actions taken against provider

[6]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.

licenses and certain health care-related judgments and conviction; and

- United States Postal Service (USPS) Address Matching System tool, a tool used to identify mailing address delivery point information.

For additional information about how we compared community providers in PPMS to the data sources noted above, see appendix I. Figure 11 in the appendix details our data analysis.

We assessed the reliability of the PPMS data we received from VHA, as well as the data sets used for matching, by performing electronic tests to determine the completeness and accuracy of key fields. We also reviewed agency documentation regarding the data sources. We interviewed knowledgeable agency officials about the reliability of the data, including the purpose, structure, definitions, and values for selected fields, as well as any limitations of the data. Overall, we found that the data were generally reliable for our purposes, including matching to exclusionary datasets to identify indicators of potentially ineligible providers.

We identified some limitations to the data that may yield understated results. First, due to technical issues with PPMS, VA was unable to provide us with a complete list of all VCCP providers in the system. Second, because Social Security Numbers (SSN) are not stored in PPMS, 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. Not all of the providers in PPMS had a SSN on file with the NPPES NPI registry, which limited our ability to match these providers to some of our exclusionary data sources. Due to these factors, the results of our aggregate analysis may be understated.[7]

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 VHA's oversight mechanisms may or may not be working. In selecting case studies, we identified providers in PPMS who

[7]The NPPES registry may not have an SSN for providers because the NPI is an organization NPI, which would not have a SSN.

- appeared on the HHS OIG LEIE,
- appeared on the GSA SAM Exclusions file,
- were reportedly deceased,
- had NPIs that may be associated with ineligible providers,
- had a post office box listed as a practice address, or
- had a practice location outside of their designated VA Community Care Network.

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.

We conducted this performance audit from October 2019 through December 2021 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.

# Background

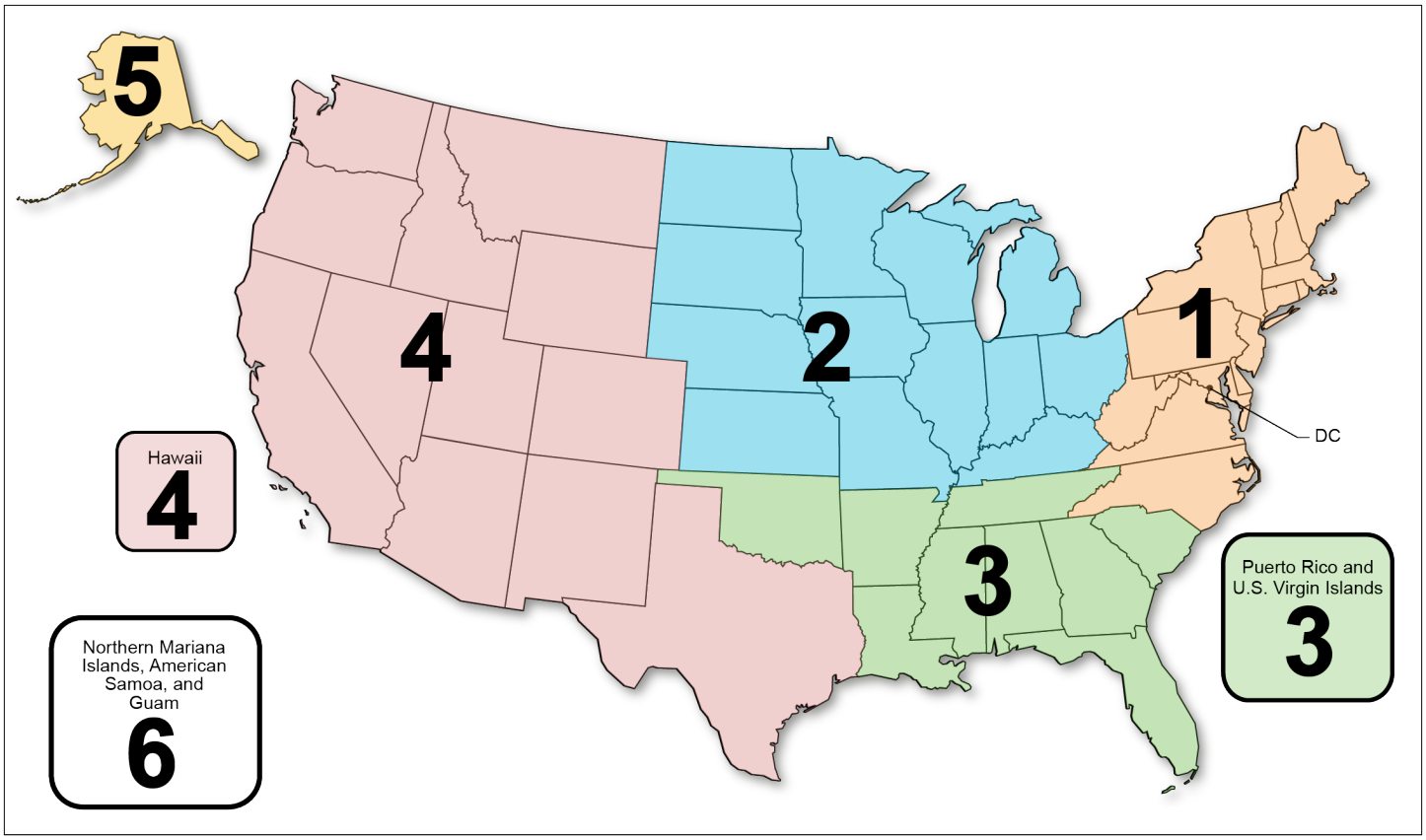
## Veterans Community Care Program

VA created the VCCP on June 6, 2019, in response to the VA MISSION Act requirement to establish a permanent community care program. The VCCP consolidated and replaced many of VA's existing community care programs into one program aimed at providing care to veterans in need when providers at VA medical facilities could not reasonably deliver care.

VA awarded contracts to two TPAs to develop and administer five of the six regional networks that make up the Community Care Network—Optum Public Sector Solutions, Inc. (Optum, Regions 1-3) and TriWest

Healthcare Alliance Corp. (TriWest, Regions 4 and 5). These TPAs are responsible for recruiting, building, and managing networks of health care community providers, among other duties. In September 2021, VHA officials stated that services for Region 6 will be covered under the contract for Region 4.[8] See figure 1.

**Figure 1: Community Care Network Regions**




Source: GAO analysis of Department of Veterans Affairs information (data); Map Resources (map). | GAO-22-103850

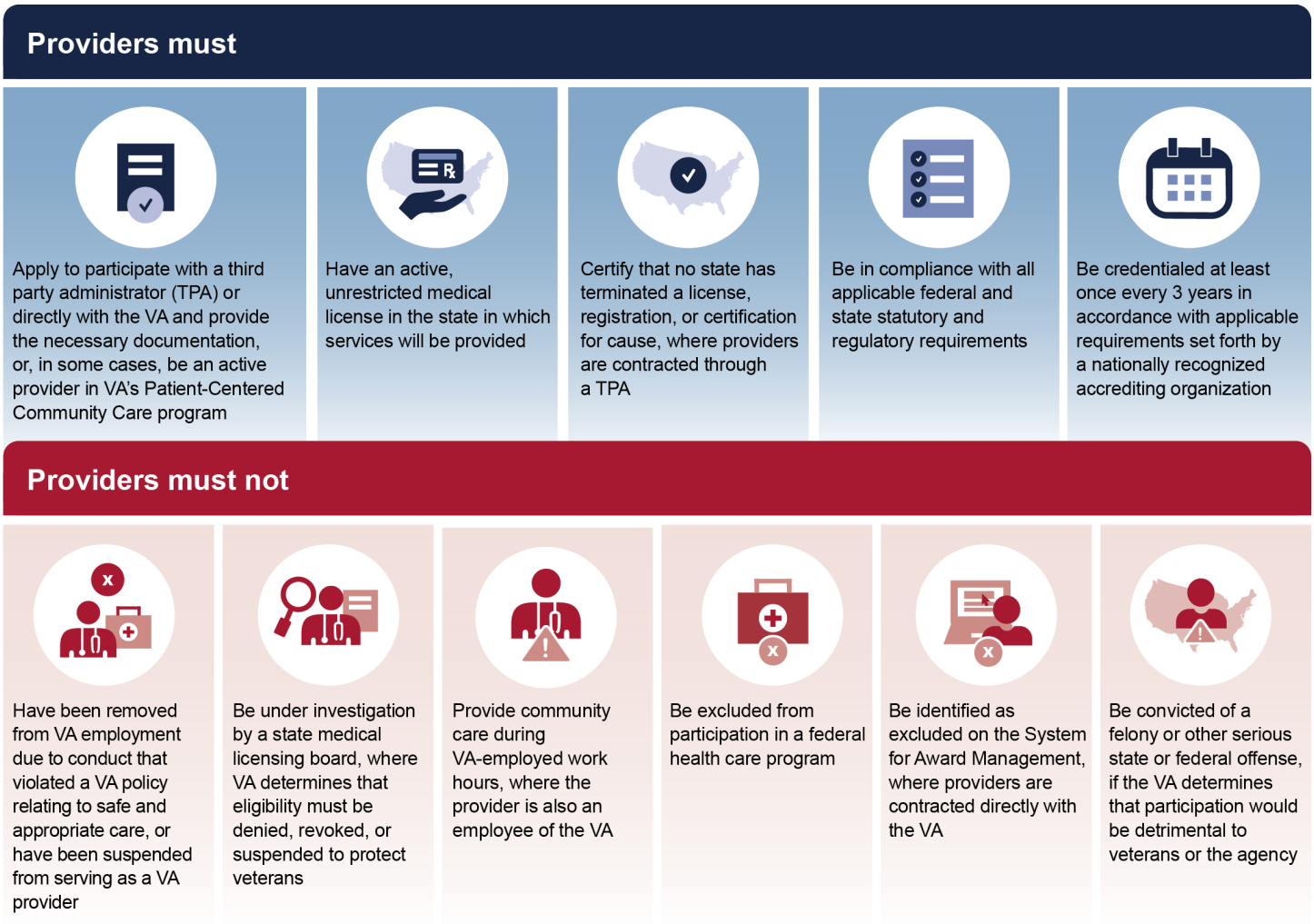
[8]The VCCP consolidated VA's previous community care programs, including the Patient-Centered Community Care program. VA fully implemented Patient-Centered Community Care in 2014, and awarded contracts to two TPAs to develop regional networks of community providers to deliver care when such care was not feasibly available from a VA medical facility. The existing Patient-Centered Community Care network will transition out from a VA medical center when the new network of community providers under the VCCP is live at that facility.

According to VHA officials, as of July 2021, about 1.2 million providers were listed as “active” throughout the Community Care Network, meaning the providers were eligible to receive patient referrals through the VCCP. VHA officials further stated that providers that are no longer able to receive patient referrals because they are ineligible or no longer wish to participate remain in PPMS, but are listed as “inactive” with the reason for inactivation.

## Laws, Regulations, and VHA Guidance Outlining VCCP Provider Eligibility

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 the graphic below.

**Figure 2: Requirements of and Restrictions on Veterans Community Care Program Provider Eligibility as of September 2021**




Source: GAO analysis of Department of Veterans Affairs (VA) information. | GAO-22-103850

The VA MISSION Act also

- prohibited VCA providers listed on GSA's SAM Exclusions file from participating in the VCCP.
- prohibited participation of providers who were ineligible to participate in federal health care programs based on Medicare and Medicaid

requirements—which specifically relate to felony convictions and health care fraud or other financial misconduct.[9]

- required VA to establish procedures for screening providers according to the fraud, waste, and abuse risks standards established in section 1866(j)(2)(B) of the Social Security Act (42 U.S.C. 1395cc(j)(2)(B)) and section 9.104 of title 48, Code of Federal Regulations, or successor regulations.
- required VA to deny eligibility to providers who violated the requirements of a medical license that resulted in the loss of such medical license.
- required VA to establish criteria under which VA must deny, revoke, or suspend a provider's eligibility to provide care to veterans through the VCCP.[10]
- granted VA the authority to exclude providers from the VCCP if VA determined it necessary to immediately protect the health, safety, or welfare of veterans. This authority further extended to providers under investigation by medical licensing boards.[11]

## Provider Credentialing Standards

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a provider to deliver care or services in or for a health care organization. The TPAs are required by their VA contracts to verify the credentials of each provider prior to enrolling them in the Community Care Network. The TPAs are further required by their contract and accreditation standards to routinely revalidate the eligibility of providers serving in their Community Care Network regions. Credentialing and validation help to ensure that veterans receive safe, high-quality care through the VCCP.

A health care provider's credentials are documented through licensure and certifications, educational achievements, training, work experience, and other qualifications. State licensing boards issue licenses and certifications to health-care providers, including, but not limited to, physicians, dentists, social workers, and nurses. These state boards are

[9]Section 1128 of the Social Security Act (as codified at 42 U.S.C. §1320a-7) (and from Medicare and State health care programs under section 1156 of the Social Security Act as codified at 42 U.S.C. §1320c-5).

[10]Pub. L. No. 115-182, tit. I, § 108, 132 Stat. 1393, 1416-1417 (2018).

[11]The VA MISSION Act stipulates that VA is not required to use this authority.

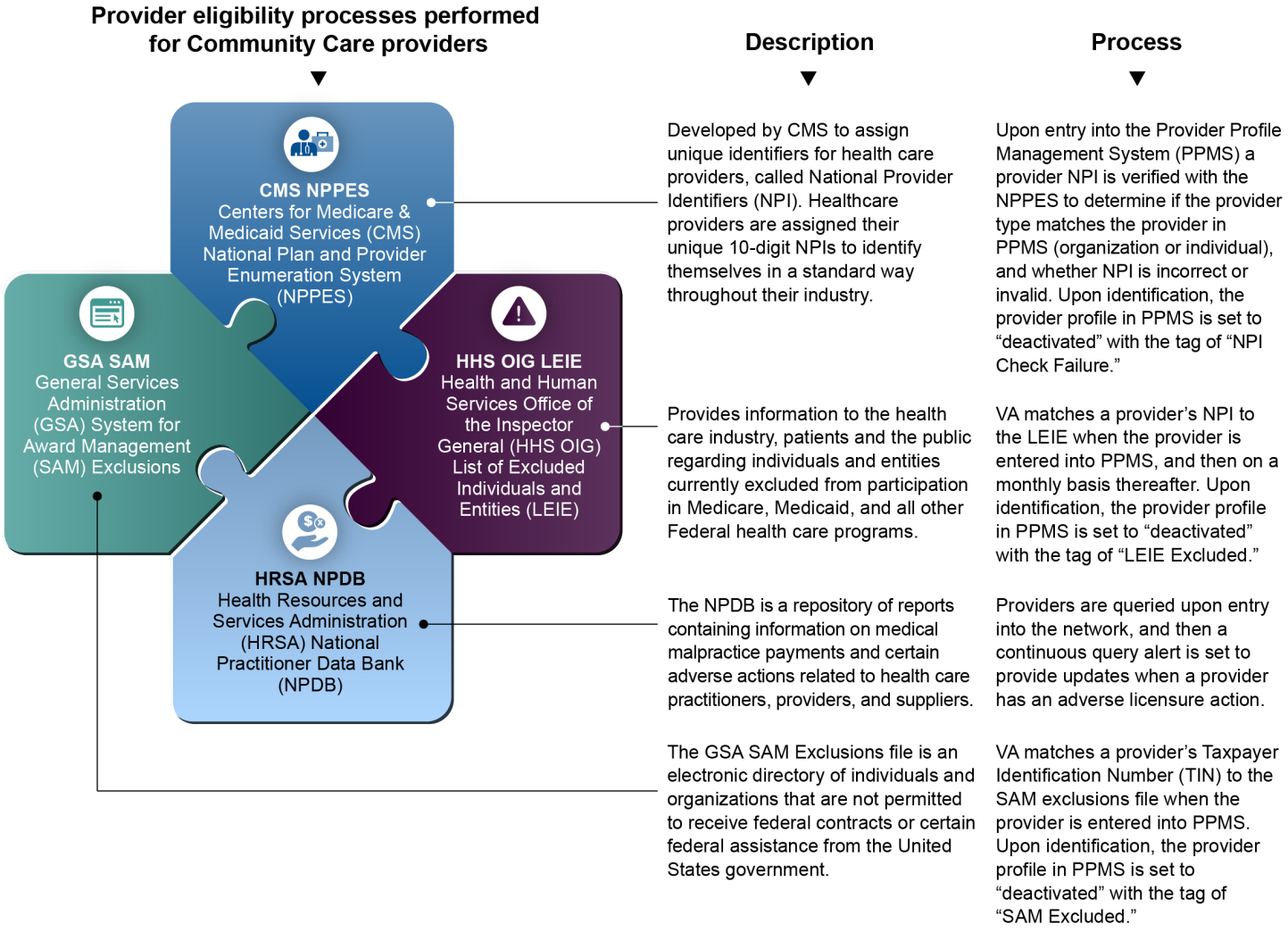
also responsible for regulating the medical profession, investigating complaints, and disciplining providers who violate the law or regulations. Licensing boards can take a number of adverse actions against a provider such as suspending, restricting, and revoking a provider's license to practice.

## VCCP Provider Oversight Exclusionary Data Sources

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 3 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 3: Summary of Veterans Community Care Program Exclusionary Data Sources and Oversight Functions**




Source: GAO analysis of publically available and federal database information. | GAO-22-103850

## List of Excluded Individuals and Entities

The HHS OIG manages the LEIE, which contains a record of those individuals and entities who are prohibited from participating in federal health care programs, such as Medicare, Medicaid, and any other federally funded health care program like that operated by VHA.[12] The LEIE database is publically available in two formats. The first is a website portal that allows users to query individuals and entities by name.

[12]Section 1128 of the Social Security Act (as codified at 42 U.S.C. §1320a-7).

Second, HHS OIG also has downloadable databases that allow users to identify excluded individuals and entities by various means, for example by name or NPI.

Exclusions from federal health care programs are imposed for a number of reasons, but generally fall into two categories: those where the HHS OIG has permissive authority to exclude individuals or entities; and those over where HHS OIG has a mandatory authority to exclude individuals or entities. Exclusions under the permissive authorities include reasons such as misdemeanor convictions related to controlled substances and the suspension, revocation or surrender of a license to provide health care, among other reasons. Mandatory exclusions, on the other hand, generally involve more serious offenses such as convictions for Medicare or Medicaid fraud or crimes related to patient abuse, as well as felony convictions relating to health care fraud or controlled substances.

The HHS OIG has the authority to waive exclusions from federal health care programs for individuals and entities. An individual or entity excluded under the mandatory authorities in sections 1128(a)(1), (a)(3) or (a)(4) of the Social Security Act may be eligible for a waiver only when the excluded individual or entity is the sole community physician or the sole source of essential specialized services in a community AND the exclusion would impose a hardship on beneficiaries of that program. (An individual or entity excluded under section 1128(a)(2) of the Social Security Act as a result of a conviction related to patient abuse or neglect is not eligible for a waiver.) For an individual or entity excluded under OIG's permissive exclusion authorities (section 1128(b) of the Social Security Act), a waiver may only be granted if OIG determines that imposition of the exclusion would not be in the public interest.

### System for Award Management

The GSA SAM is a public federal database of all entities doing business with the federal government. The SAM Exclusions file includes health care entities, individuals, or organizations barred from doing business with the federal government or from receiving payments from federal programs.

Information on excluded entities from the LEIE is also included in the SAM Exclusions file. Additionally, HHS OIG officials said that the LEIE contains more specific information on health care providers' exclusions than what is presented on the SAM Exclusions file. However, the LEIE is limited to exclusion actions taken by the HHS OIG.

Conversely, SAM contains all actions of federal branch agencies to exclude entities from participating in federal programs. For example, the SAM Exclusions file lists individuals who have been debarred by the Office of Personnel Management from participation in federal employee health benefit programs, which the LEIE does not include.

### National Plan and Provider Enumeration System

As mentioned above, CMS' NPPES assigns individual or organizational health care providers a unique 10-digit identifier called an NPI. The NPI is the standard identifier throughout the medical industry.[13] NPIs are publically available via the NPPES NPI registry, which documents records attached to a health care provider's NPI such as provider name, practice location, and area(s) of specialty.[14] Providers maintain the same NPI when they change office locations or specialties. Providers are required to report changes like these to the NPPES.

VHA officials told us the provider NPI is one of the required identifiers that must be provided by the individuals and entities wishing to participate in the VCCP. Because the NPI is a unique identifier, VHA stated it uses NPI to reduce personal security risk to providers.

CMS releases monthly a list of NPIs that have been deactivated in NPPES and the dates of the deactivation. While PPMS does not explicitly screen for deceased providers, the NPPES monthly deactivation file serves as a proxy for the identification of deceased individuals. The data for the deactivation of NPIs is partly sourced from the SSA, which reports to CMS the NPIs of deceased people for deactivation in NPPES.

### National Practitioner Data Bank

When credentialing providers, TPAs may query the NPDB to identify actions that disqualify providers from participating in the VCCP.[15] The NPDB contains information on health-care providers who have been disciplined by a state licensing board, professional society, or health-care

[13]The NPI system was created by Congress as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191 which, among other things, required the adoption of standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system and to specify the purposes for which the identifiers may be used.

[14]Taxonomy is the word used in NPPES to refer to a provider's medical specialty or area of focus.

[15]HRSA—an agency within HHS—maintains the NPDB. The NPDB was established by Congress in 1986 by Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA), Public Law 99-660.

entity, have been named in a health care-related judgment or criminal conviction, or have been identified in some other adverse action.[16]

According to HRSA—the agency that maintains the NPDB—approximately 24,000 entities interact with the NPDB. According to HRSA officials, approximately 700 state licensing-board entities are registered with the NPDB.[17] These licensing-board entities are responsible for reporting different types of actions depending on their role and relationship with the provider. The NPDB receives information from state licensing boards, as well as hospitals, health plans, and federal and state agencies, among other entities.

The NPDB offers a continuous query alert function that can notify TPAs if a provider has an adverse action, such as a revoked or surrendered license.[18] While the VA MISSION Act and VA contracts did not require TPAs to use NPDB when credentialing providers, our prior work recommended that VA ensure that TPAs develop and implement a process for continuous monitoring of eligibility requirements.[19] Specifically, we recommended that the following:

- VA require the TPAs to amend their 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, and
- VA ensure that TPAs develop and implement a process for continuous monitoring of eligibility requirements in section 108 of the VA MISSION Act.[20]

[16]We refer to negative licensure or judgments against health care providers collectively as "adverse actions."

[17]HRSA officials noted that not all of the approximately 700 entities license health-care providers; some license health-care entities, such as hospitals, and medical suppliers. They also noted that some entities are made up of several licensing boards that interact with the NPDB administratively as a single entity, even though within the state's structure the boards are separate.

[18]Both TPAs use the NPDB to verify provider submitted information and credentialing documentation.

[19]GAO-21-71.

[20]GAO-21-71.

VA concurred with both recommendations, but as of August 2021 they had not been implemented. In September 2021, VHA Office of Community Care officials stated they were working with the TPAs to address these recommendations.

## Framework for Managing Fraud Risks in Federal Government

In July 2015, we issued a Framework for Managing Fraud Risks in Federal Programs, which provides a comprehensive set of key components, overarching concepts, and leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based way.[21] The Fraud Risk Framework states that program managers should determine the types of internal and external fraud risks programs may face, such as fraud related to financial reporting, misappropriation of assets, corruption, and nonfinancial forms of fraud. These broad categories of fraud encompass specific fraudulent schemes related to contracting, grant-making, beneficiary payments, payroll payments, and other areas of government activity.

## Standards for Internal Control in the Federal Government

In September 2014, we issued the Standards for Internal Control in the Federal Government.[22] According to federal internal control standards, managers should identify, analyze, and respond to risks. Additionally, prior GAO work shows that managers should be responsible for proactively managing risks, including fraud risks and misconduct such as waste and abuse. Managing risks facilitates the entity's mission and strategic goals by ensuring that taxpayer dollars and government services are being used for their intended purposes.

# 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.

Specifically, we found that VA did not exclude or remove

- 27 active providers listed on the HHS OIG LEIE,

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

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

- 16 active providers listed on the SAM Exclusions file,
- 601 deceased providers with inactive NPIs listed as active in PPMS,
- 216 active providers who had a revoked medical license,
- 796 active providers who surrendered their licenses in response to investigation, or
- 37 providers who had a fraud-related judgment or conviction.[23]

Similar to the vulnerabilities of eligibility controls described above, VHA's address verification processes are not designed to identify indicators of potential fraud. We identified 66 providers whose practice addresses were commercial mail receiving agencies (CMRAs), such as a United Parcel Service (UPS) store, and did not meet the requirements outlined in VCCP contracts.

[23]There may be potential overlap from these counts. It is a possible for a provider to appear in one or more of the datasets we reviewed for our work. For example, the SAM Exclusions file contains information from the LEIE.

## Vulnerabilities in VHA and TPA Provider Eligibility Controls Did Not Exclude All Providers When They Became Potentially Ineligible

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

**Health and Human Services Office of the Inspector General (HHS OIG) List of Excluded Individuals and Entities (LEIE)**

Source: GAO analysis of Department of Health and Human Services information. | GAO-22-103850

**Detecting LEIE Excluded Provider**

A provider was added to the LEIE in June 2020 for a mandatory exclusion related to a criminal conviction. VHA's LEIE check inactivated the provider in PPMS in June 2020. Prior to the LEIE exclusion, the provider was active as part of a prior VA community care program and was eligible for VCCP referrals.

Source: GAO. | GAO-22-103850

**VHA Office of Community Care LEIE Match Procedures**

As of June 2020, VHA Office of Community Care Provider Exclusion Standard Operating Procedures stated that VHA was to perform automated LEIE checks on new providers as they were first on-boarded as a new community care provider in PPMS. Further, the standard operating procedures stated that ongoing, automated monthly checks should be performed for providers already in PPMS.[24] To determine whether providers were included on the LEIE, and thus ineligible to join the Community Care Network or to have a VCA, VHA Office of Community Care compares data from the LEIE to provider data included in PPMS.

VHA Office of Community Care officials stated that VA's Business Integrity and Compliance Department of in its Program Integrity office provides a monthly updated LEIE file to be loaded into PPMS. To perform these checks, VHA matches providers' NPIs against NPIs found in the LEIE. VHA marked any matching providers between the datasets as "inactive" in PPMS, which made the providers ineligible to receive referrals. VHA standard operating procedures outlined, and VHA Office of Community Care officials confirmed, that NPI was the only field used by VHA to match the LEIE and PPMS data. See the sidebar for an example of how this process succeeded in promptly inactivating a provider's record in PPMS soon after the provider was added to the LEIE.

According to VHA officials, PPMS does not contain providers' SSNs, and VHA Office of Community Care officials stated that a System of Records Notice (SORN) is required for VHA to store SSN and date of birth data for

[24]VA officials stated that a February 2021 update to PPMS enabled the monthly automatic checks of PPMS provider information. Prior to the February 2021 PPMS update, LEIE checks were performed manually and on a less regular basis using user acceptance testing.

VA Community Care Network providers in PPMS.[25] VHA officials stated that they did apply and receive a SORN to store and collect provider date of birth data. However, according to VHA officials, the SORN for the date of birth data was received after the Community Care Network contracts to the TPAs had been executed. As a result, VHA officials said that provider date of birth is not a required field for the TPAs to report. VHA Office of Community Care officials stated that the amount of time it took to process the date of birth SORN led them to believe that obtaining an additional SORN for SSN would be cost prohibitive. The officials noted that in addition to obtaining a new SORN, the TPAs' contracts would need to be modified in order to require them to report SSNs.

### TPA LEIE Match Processes

VHA Office of Community Care officials stated that the automated LEIE check performed in PPMS is an additional check of the screening performed by the TPAs. Further, officials stated that the TPAs are mandated to check providers for LEIE exclusion and have the ability to collect a provider's SSN and date of birth, which, as noted above, is not permitted to be stored in PPMS. The TPAs ability to screen Community Care Network providers by SSN and date of birth, where VHA is not permitted to collect and use provider SSN. However, the current TPA contracts do not specify how frequently the TPAs should check PPMS providers against the LEIE.

VHA Office of Community Care officials stated that the TPAs are required to use the LEIE to screen all new providers before enrolling them in the Community Care Network for the first time. The TPAs used provider information such as SSN or Taxpayer Identification Number (TIN), NPI, and other identifying information given by the providers to enter the Community Care Network to compare against the LEIE.

TriWest officials stated that they compare the LEIE with their network providers, using NPI, core provider name, SSN or TIN on a monthly basis. Optum officials stated that providers who request participation in a Community Care Network and require credentialing have sanction checks performed as part of the initial credentialing and re-credentialing process. Re-credentialing occurs every 36 months or less. Additionally, Optum officials stated that they perform ongoing monitoring of the LEIE on a

[25]Whenever a federal agency maintains information about an individual in a system of records and retrieves the information by a personal identifier, it must publish a SORN in the Federal Register. 5 U.S.C. § 552a(f).

monthly basis. Optum officials stated that they search the LEIE using provider name or NPI, and then confirm that the SSN and provider name match to validate the results.

### We Identified LEIE Excluded Providers in PPMS

Of the 826,101 providers in our analysis, we identified 47 providers in PPMS who were on the LEIE. Twenty-seven of the 47 providers were "active" in PPMS as of September 2020.[26] The other 20 providers were listed as "inactive" in PPMS as of March 2020. As noted previously, "active" providers in PPMS are eligible to receive patient referrals through the VCCP. VHA officials said that providers who are "inactive" are not able to receive referrals, but remain in PPMS.

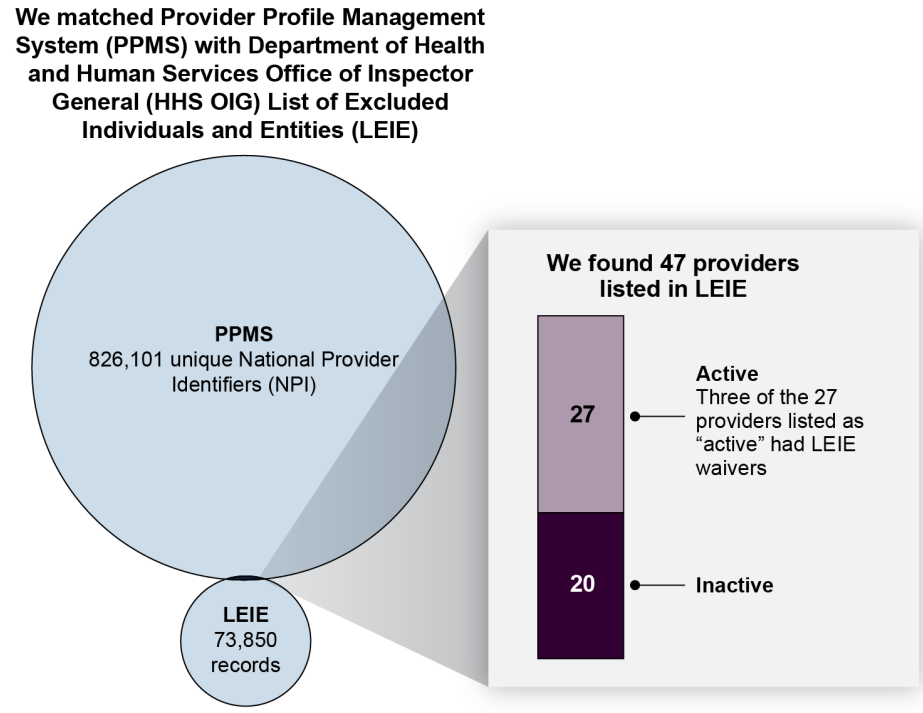
We identified these providers by using SSN or TIN as the matching field in LEIE, in addition to NPI. We reviewed 28 of the 47 providers who we identified using an exact match, comprised of both active and inactive providers. Three of the 28 providers we identified had LEIE waivers, and per VHA protocols, were not considered to be excluded. See our discussion below for more information on the providers who received waivers. Of the remaining 25 providers we reviewed, VHA deactivated seven of the 25 providers by March 2021, after VA had changed its procedure for uploading the LEIE exclusion data to PPMS for review and deactivation of LEIE excluded providers.[27] The average time between when a provider was listed on the LEIE and when a provider was deactivated by VHA in PPMS was nine months. The length of time from when a provider was listed on the LEIE to their deactivation in PPMS ranged from four months to 18 months.

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.

[26]Our analysis identified 47 providers listed on the LEIE in total. As noted in the example above, we found some instances where the VA controls identified LEIE excluded providers.

[27]We did not include the three providers who have LEIE waivers in our calculations. Per VHA protocols, these providers remain eligible for referrals. VHA officials stated that in March 2021 they changed procedures for uploading the LEIE exclusion data to PPMS. At this time they identified additional providers listed on the LEIE, including providers that were previously listed as inactive in PPMS.

**Figure 4: Results of PPMS and HHS OIG LEIE Data Analysis**




Source: GAO analysis of Department of Veterans Affairs and HHS OIG LEIE information. | GAO-22-103850

## Sole Use of NPI as a Match Field Has Limitations

We used SSNs to match providers to the LEIE for four reasons. First, HHS OIG officials informed us that the LEIE does not list an NPI for every provider. Specifically, HHS OIG only includes NPIs on providers' LEIE records if the NPI can be verified in NPPES.[28] Second, not all providers on the LEIE are eligible for an NPI. Specifically, according to HHS OIG officials, the majority of people that HHS excludes—such as office administrators, nurses, and clinic workers—do not have an NPI. Third, the LEIE did not list NPIs for provider exclusions prior to 2008.[29] Fourth,

[28]HHS OIG uses provider identifying information from NPPES, such as address, and license number, if applicable, to verify that an NPI matches the provider in question.

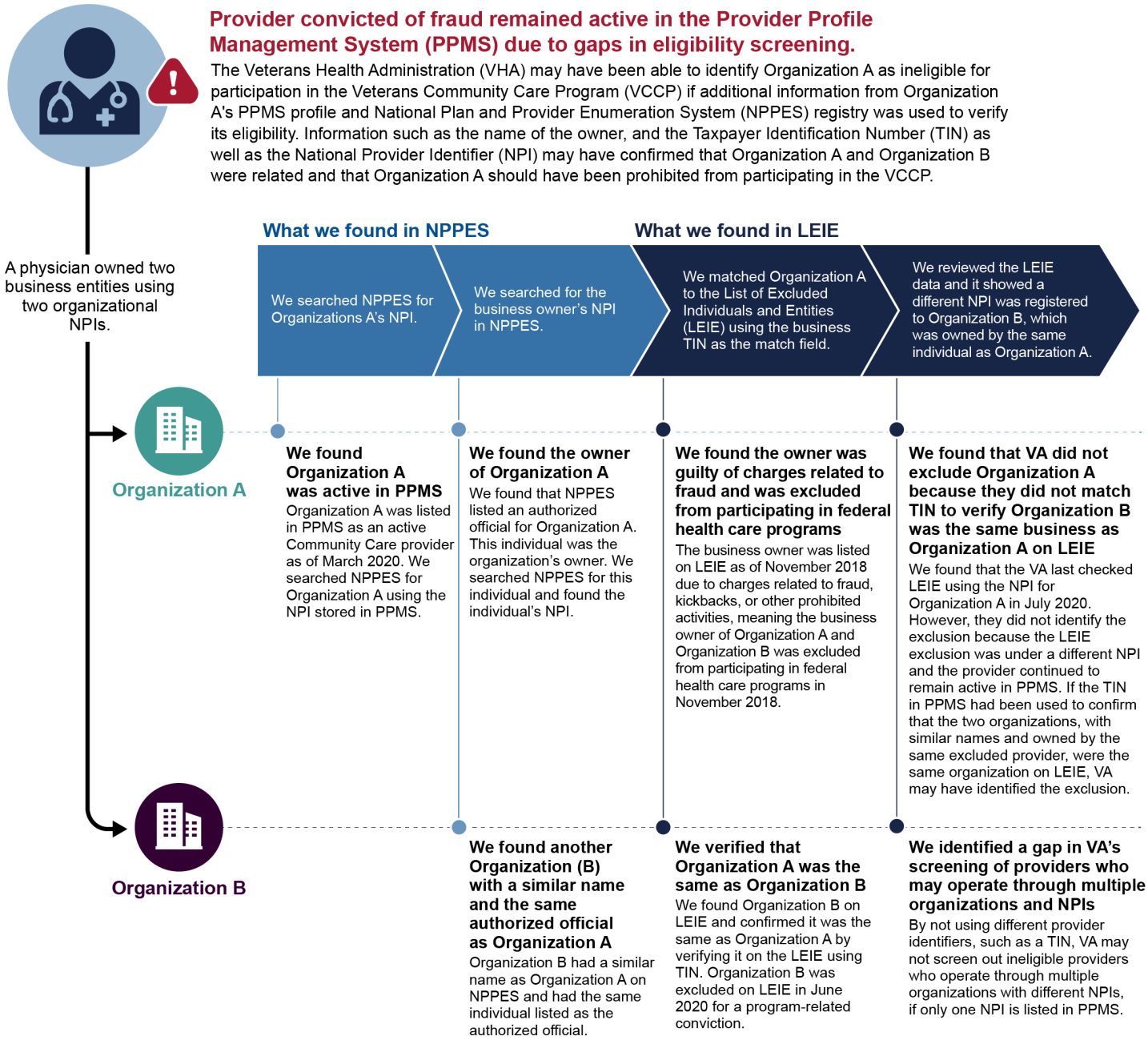
[29]The HHS OIG added NPI data to the LEIE records for all NPI-eligible providers starting in 2008. LEIE used the NPPES database to obtain the NPI information for excluded entities. However, officials from the HHS OIG stated that they only added the NPI number to LEIE excluded providers for which they also matched SSNs or dates of birth.

some providers in PPMS listed an organizational NPI, as opposed to an individual NPI.[30] 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.

For example, one provider we identified had an individual NPI and multiple organizational NPIs registered in NPPES. One of the organizational NPIs was active in PPMS as of March 2020. The physician and the organization listed in PPMS pleaded guilty to making a false statement to a financial institution and health care fraud in November 2018. The individual was also added to the LEIE in November 2018. However, only one of the organizational NPIs owned by this individual was listed on the LEIE, added in June 2020. The organization was deactivated from PPMS in August 2020, nearly two years after the business owner was listed on the LEIE. Had VA matched the SSN or TIN fields between the LEIE and PPMS, as we did, the agency may have identified this and other ineligible individual providers sooner. See figure 5 below.

[30]NPPES has two types of provider NPIs, 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.

**Figure 5: Illustrative Example - Excluded Provider with Multiple NPIs**




Source: GAO analysis of Department of Veterans Affairs and publically available information. | GAO-22-103850

## VHA Did Not Implement LEIE Match Procedures

While our review found that VHA did periodically match the LEIE to providers in PPMS, 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.

In July 2021, the VHA Provider Standard Operating Procedures had not been fully implemented as required by policy. The LEIE file transfer process from VA's Business Integrity and Compliance Department of Program Integrity could not be performed automatically; instead the LEIE file was manually uploaded into PPMS. VHA officials explained that the file had to be manually uploaded because PPMS did not have the functionality to automatically upload the LEIE file from HHS OIG and compare it to the community providers in PPMS.

Further, VHA Office of Community Care officials noted their Business Integrity and Compliance Department of Program Integrity was occasionally delayed by a week in providing the LEIE file to the Office of Community Care because of the manual transfer process. Our case study work suggests that the LEIE checks were not performed on a monthly basis, as outlined in the standard operating procedures. Additionally, as of July 2021, VHA stated they have not prescribed how frequently the TPAs should perform LEIE checks.

See the sidebars for two examples of how the absence of monthly checks allowed providers to remain active in PPMS after they were added to the LEIE.

**Provider Remained Active in PPMS Due to Limited Search Criteria**

As a result of our work, we identified a provider who was deactivated from Community Care Network Region 2 in July 2020 but was still active in PPMS to provide care in Community Care Network Region 1 until March 2021, according to VHA officials. The TPA for both of these Regions had not credentialed the provider since October 2007 and information from the TPA indicated that it removed the provider from the Community Care Network. The validation check in PPMS last matched the provider to the LEIE in May 2020. VHA stated that the provider's NPI was not on the LEIE exclusion list that the VA had on file. However, we identified this provider using SSN. This provider was on the LEIE in August 1997 for a felony conviction of Medicaid fraud, but as of March 2021, but the provider was still listed as active in PPMS.

Source: GAO. | GAO-22-103850

## VHA Does Not Account for LEIE Waivers in PPMS

HHS OIG has the authority to issue waivers, which waive an individual's or entity's exclusion from participation in federal health care programs in specific geographic areas or for a specific type of care. A waiver may only be requested by the administrator of a federal health care program. As previously discussed, an individual or entity excluded under the mandatory authorities in sections 1128(a)(1), (a)(3) or (a)(4) of the Social Security Act may be eligible for a waiver only when the excluded individual or entity is the sole community physician or the sole source of essential specialized services in a community AND the exclusion would impose a hardship on beneficiaries of that program. (An individual or entity excluded under section 1128(a)(2) of the Social Security Act as a

result of a conviction related to patient abuse or neglect is not eligible for a waiver.) For an individual or entity excluded under OIG's permissive exclusion authorities (section 1128(b) of the Social Security Act), a waiver may only be granted if OIG determines that imposition of the exclusion would not be in the public interest. Three of the 28 active providers mentioned previously had waivers, which permitted the providers to participate in federal health care programs within certain geographic locations.[31] VHA told us that these three providers with waivers were active in all geographic areas by default because PPMS did not have the capability of distinguishing providers' eligibility status by geographic region.[32] This means that schedulers are unable to determine whether the provider meets the parameters set forth in the waiver.

**Delay in Detecting LEIE Excluded Provider**

As a result of our work, we identified a provider who had an expired nursing license in April 2016 and was arrested for assault in October 2018. This provider was added to the LEIE for patient abuse or neglect in July 2019. VHA officials told us they added the provider into PPMS in November 2019. VHA officials stated that this provider was uploaded into PPMS in error. A physical therapist with the same last name should have been loaded into PPMS. However, the excluded provider was included instead. VHA officials stated they corrected this error in November 2020, a year after the provider was included in PPMS.

Source: GAO. | GAO-22-103850

Optum officials stated that there were a minimal number of providers with waivers in their network, none of which were participating in the network as of August 2021. Optum officials were not aware of specific controls in place to allow waiver specifications to be transferred to the VA. TriWest officials stated that there was not a provider waiver indicator in TriWest data, nor was there a requirement in the PPMS file to notify that a provider had an LEIE waiver.

As such, there is currently no mechanism in place to share provider waiver information in PPMS or downstream with VA medical center appointment schedulers in that region to ensure the provider is only used for care in the geographic region covered by the waiver. As a result, veterans are at risk to receive care from individuals who may be ineligible to participate in the Community Care Network.

[31]As of August 2021, HHS OIG only has waivers for 10 providers in total. Three of those providers are in the VCCP.

[32]In some cases, individual and entities with NPIs on the LEIE 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 the services are required and they are not allowed to provide service under a federal health care program outside of the selected area.

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

**General Services Administration (GSA) System for Award Management (SAM) Exclusions**

Source: GAO analysis of Department of Health and Human Services information. | GAO-22-103850

**VHA Office of Community Care SAM Exclusion Match Procedures.**

VHA Office of Community Cares', June 2020 Provider Exclusion Standard Operating Procedures stated that automated checks were to be performed on providers against the SAM Exclusions file as they were first on-boarded as a new community care provider in PPMS. The standard operating procedures further stipulated that providers in PPMS should be checked against SAM on a monthly basis thereafter. Similarly, Section 102 of the VA MISSION Act requires that VCA providers participating in the VCCP be compared to the SAM Exclusions file.

To perform these checks, VHA matches the providers' TIN in PPMS against TINs found in the SAM Exclusions file.[33] VHA marks any matching providers between the datasets as "inactive" in PPMS, which makes the providers ineligible to receive referrals.

**TPA SAM Exclusion Match Processes**

VHA officials stated that the screening controls described above were intended to be secondary checks to those run by the TPAs. VHA Office of Community Care officials stated that while the Community Care Network contracts did not require the TPAs to match providers against the SAM Exclusions file, the TPAs did have controls in place to intermittently check providers against the SAM Exclusions file. Specifically, Optum officials stated that they verify providers through the SAM Exclusions public website for Licensed Independent Practitioners.[34] Optum officials stated these providers were screened using provider name and SSN or TIN. Optum officials stated they check providers against the SAM Exclusions file when they join the network and 36 months or less thereafter. TriWest officials stated they only check SAM for Single Care Agreement facilities —a one-time agreement specific to a provider, a veteran, and an episode of care where there is not a network contract with the provider.

[33]TINs are taxpayer identification numbers. According to the IRS, a SSN is a type of TIN for individual taxpayers. VHA officials stated that if a provider uses their SSN as a TIN for participation and billing in the VCCP, it is the provider's prerogative.

[34]Licensed independent practitioners are providers who are permitted by law and the VA medical facility to provide patient-care services independently, without supervision or direction. Dependent providers, such as registered nurses, provide patient care under the supervision or direction of a licensed independent practitioner.

**Provider with Health Care Fraud Conviction Not Detected by LEIE Search**

A provider lost his nursing license and was added to the LEIE in March 2018 for health care fraud. This provider was initially a network provider under the previous VA community care program, the Veterans Choice Program, and was terminated by the TPA in 2017. In addition, the provider's name is different on the NPPES registry than in any other documentation we reviewed. The provider certified the accuracy of the information on NPPES in December 2019, after the provider had been added to the LEIE. The provider billed VA for services in August and September of 2019 for a total of $268.04. The provider was not deactivated in PPMS until April of 2019, but billed for services in August and September of 2019. VA officials told us that the provider remained active in PPMS but was flagged as unavailable for veteran referrals as of April 2019. We identified this provider by using his name, date of birth, and social security number to look up and confirm his profile on the LEIE database. Although VA officials told us that an inactive service status in PPMS meant a provider could not be referred to veterans, this provider billed for services.

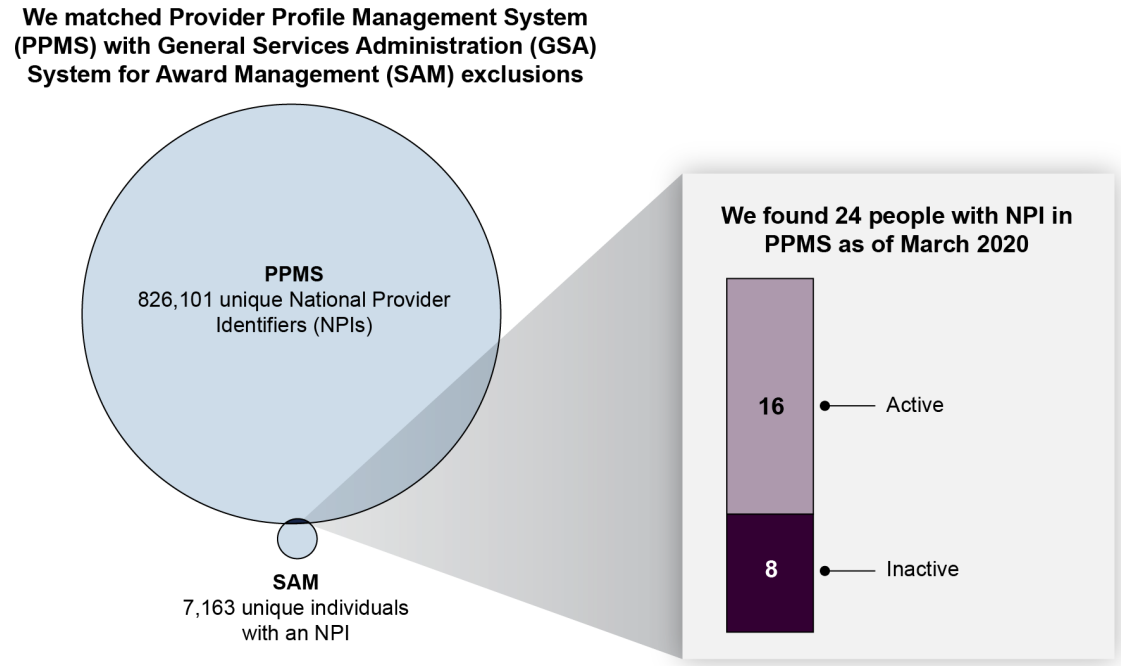
Source: GAO. | GAO-22-103850

## Our Analysis Identified SAM Excluded Providers in PPMS

We identified 24 out of 826,101 community care providers included on the SAM Exclusions file, 16 of whom were listed as active providers in PPMS as of March 2020. The other eight providers were listed as deactivated prior to March 2020. Of the providers we identified on SAM, seven were excluded by the Office of Personnel Management OIG.

We identified these providers by matching on NPI, which is available for all providers in PPMS, and used for checks against the HHS OIG LEIE. Ineligible providers listed on the SAM Exclusions file remained active in PPMS because 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. In December 2021, VA stated a new SAMs validation process was developed in PPMS in September 2021, where the SAM website is checked daily, and if a new update is available PPMS imports the update and validates providers on the update against providers in PPMS based on NPI. VA did not provide supporting evidence to document that this process was correctly implemented, so we are unable to assess its effectiveness.

**Figure 6: Results of PPMS and GSA SAM Data Analysis**




Source: GAO analysis of Department of Veterans Affairs and GSA information. | GAO-22-103850

**Delay in Detecting SAM Excluded Provider**

As a result of our work, we identified an internal medicine physician who had his medical license suspended in three states after he was indicted for conspiracy to commit health-care fraud in April 2019. The provider was subsequently added to the SAM in July 2019. The provider remained active in PPMS as of March 2020, though he did not provide any services to veterans since losing his medical licenses. The provider was not deactivated by the TPA until November 2020, over a year after the provider was excluded. We identified this provider by matching his NPI to the SAM Exclusions file.

Source: GAO. | GAO-22-103850

## Sole Use of TIN as a Match Field Has Limitations

Further limiting screening, VHA used providers' TINs, without also checking for NPIs, to match against the SAM Exclusions file. VHA officials stated that provider TINs were not consistently populated in PPMS. Meanwhile, all providers in PPMS were required to furnish an NPI. While there are limitations to the sole use of NPI as a match field, as noted above, using additional 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.

**SAM NPI Match Went Undetected**

As a result of our work, we identified a physical therapy practice with an active SAM exclusion as of December 2019 that remained active in the PPMS as of June 2021. We identified this provider by matching the provider's organizational NPI to the SAM Exclusions file. VA's PPMS records indicated that the provider was last matched against SAM in August 2019.

Source: GAO. | GAO-22-103850

## VHA Did Not Implement SAM Match Procedures

VHA's standard operating procedures called for automatically checking all providers in PPMS against the SAM on a monthly basis. VHA Office of Community Care officials stated that providers were only checked against SAM when they were first entered into PPMS and were not checked against the file again on a monthly basis. According to VHA officials, they discovered that they could not comply with the procedures as intended due to unanticipated technical limitations. Specifically, VHA officials stated that the number of providers to be checked was too large for the available system to handle.

**Delay in Detecting SAM Excluded Provider**

As a result of our work, we identified a chiropractor added to the SAM Exclusions file in January 2019 after the Office of Personnel Management sanctioned the provider. VA records indicated that this provider in PPMS was not checked against SAM due to a technical processing issue with the SAM database. The provider was deactivated by the TPA in November 2020, over 1 year after the provider was listed on the SAM Exclusions file.

Source: GAO. | GAO-22-103850

In September 2021, VHA officials stated that they were working to find alternative ways to access the SAM Exclusions file to perform on-going monitoring of community care providers.[35] We received proposed technical plans for checking the SAM Exclusions file that VHA told us would be implemented in September 2021. As of October 2021, we did not receive evidence that these plans had been implemented and were working as intended. Further, we did not receive evidence that VHA consulted with GSA to ensure the plans would address the technical issues VHA encountered. See the sidebars for examples of providers who remained active in PPMS despite being added to the SAM Exclusions file.

We identified providers that should have been excluded from providing care through the VCCP. Three of these providers remained active when we notified the VHA Office of Community Care of the presence of likely ineligible providers in PPMS.

Although we did not find instances where these providers delivered care through the VCCP, the missed matches in SAM resulted in ineligible providers remaining active in PPMS. Consequently, these providers are available to provide care through the VCCP, potentially putting veterans at risk of obtaining inadequate care from providers not eligible to participate in the program. Lastly, some of the ineligible providers we identified had convictions related to health-care fraud. While we did not identify fraudulent activity among the active, ineligible providers we identified, the risk remains that an ineligible provider could evade detection with the intention of committing fraud if screening controls are not enhanced.

[35]VHA officials stated they are revising their standard operating procedures, but do not have an estimated date these procedures will be issued.

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

**Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES)**

Source: GAO analysis of Department of Health and Human Services information. | GAO-22-103850

### VHA Office of Community Care NPI Validation Procedures

The June 2020 VHA Office of Community Care Provider Exclusion Standard Operating Procedures states automated exclusions, including checks against the NPPES registry, should be completed after the NPI is entered into PPMS, and on a monthly basis thereafter. However, the standard operating procedures do not explicitly state what data should be checked when verifying a provider's NPI.

VHA officials stated that when a provider's information was uploaded into PPMS, the provider's NPI was checked to ensure that the NPI was valid, represented the proper provider type (individual or organizational), and, once the provider was in PPMS, remained active in NPPES. Specifically, VHA officials stated that after the NPI is manually entered into PPMS, an automated process verifies the NPI is correct. Additionally, VHA officials stated that they automatically accessed the NPPES monthly deactivation file on a weekly basis and compared it with providers in PPMS to identify deactivated NPIs. The providers who matched with a deactivated NPI and were listed as "inactive" in PPMS were no longer eligible for referrals.

### TPA NPI Validation Procedures

VHA officials stated that there is no contract requirement for TPAs to check the NPPES deactivation file. Officials from Optum and TriWest stated they matched the NPPES data to federal databases on community care providers.

- Optum officials stated that they query the NPPES registry website using one of the following search fields: provider's name, NPI, taxonomy, or address. Optum considered the provider a match if the NPPES results matched the NPI provided in the credentialing file and at least one of the following: name (first and last), previous name (first and last), or provider address and provider reported taxonomy. Optum verified NPI registry information during the initial credentialing process and it is policy to verify again no less than every 36 months thereafter for re-credentialing. Optum also monitored the SSA Death Master File on a quarterly basis for providers who had expired to match records and prevent billing and identity fraud.
- TriWest officials stated that they verify providers' information with the NPPES registry during credentialing and it is policy to verify again during the re-credentialing process no less than every 36 months thereafter, using NPI, core provider name, SSN and/or TIN as match fields.

See the side bar for an example of how this NPI validation process leads to deactivating a deceased provider.

**PPMS Controls Identified Deceased Provider**

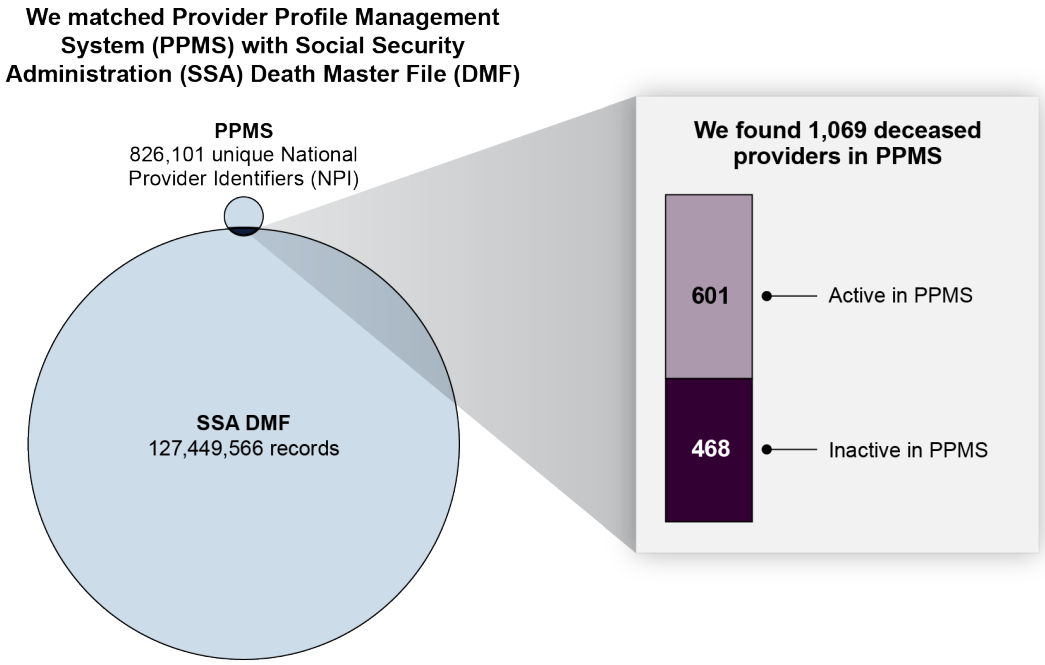
A provider was listed as deceased on the SSA Death Master File in January 2020. The NPPES monthly deactivation file showed that the provider's NPI was deactivated in February 2020. Our review of VA documentation showed that the provider was deactivated by VA in March 2020 as a result of an NPI check. VA records showed that the provider did not bill for services rendered after the provider died. Our review indicated the NPPES registry check correctly identified the deceased provider.

Source: GAO. | GAO-22-103850

### Our Analysis Identified Deceased Providers in PPMS

We matched providers in PPMS with the SSA Death Master File to determine whether deceased providers remained available for referrals through the VCCP. We identified 1,069 deceased providers in PPMS as of March 2020, of which 601 were active and, therefore, available for referrals (see figure 7).

**Figure 7: Results of PPMS and SSA Death Master File Data Analysis**




Source: GAO analysis of Department of Veterans Affairs and SSA information. | GAO-22-103850

We found that most deceased providers had deactivated NPIs in NPPES. For example, of the 1,069 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. See the sidebars for two such examples.

**Deceased Provider Received Payment Months After NPI Was Deactivated**

As a result of our work, we identified a nurse anesthetist who was listed as deceased on the SSA Death Master file in March 2019. The NPPES monthly deactivation file shows the provider NPI was deactivated in June 2019. However, VA PPMS records show the provider was not deactivated by the TPA until November 2020, over a year after her NPI was deactivated. VA PPMS records show that the provider was last checked against NPPES in 2018. Our review of VA payment data indicates the NPI associated with the provider billed for services rendered in 2020 for over $10,000. The VA PPMS checks with the NPPES monthly file did not identify this provider NPI as deactivated, which resulted in payments made to this provider's NPI after the provider died.

Source: GAO. | GAO-22-103850

**Delay in Detecting Deceased Provider**

As a result of our work, we identified an otolaryngologist who was listed as deceased on the SSA Death Master file in March 2019. The NPPES monthly deactivation file showed that the provider's NPI was deactivated in April 2019. However, the PPMS listed the provider as active as of March 2021. The NPI associated with the provider billed for services rendered in July 2019 for $2,632.77 over 3 months after the NPI was deactivated. VA records show that the provider was last matched to NPPES registry in May 2019, indicating the match performed in PPMS did not identify this provider.

Source: GAO. | GAO-22-103850

While our case study work identified instances where these controls worked as intended in validating providers' NPIs, we also identified instances in which deceased providers with deactivated NPIs were still listed as active in PPMS. Deceased providers are unable to provide veteran care, potentially causing delays in scheduling as schedulers confirm the providers' availability. Additionally, the presence of deceased providers who are active in PPMS may put VHA at risk for fraud, as someone could submit false claims in the deceased providers' names.

## TPAs Did Not Exclude 216 Providers with Revoked Licenses and 796 Providers with Involuntarily Surrendered Licenses

### VA MISSION Act Licensure Requirements

The VA MISSION Act prohibits providers from participating in the VCCP if they have violated requirements of a medical license of the health care provider that resulted in the loss of such medical license. For example, loss of license because 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

**Health Resources and Services Administration (HRSA) National Practitioner Data Bank (NPDB)**

Source: GAO analysis of Department of Health and Human Services information. | GAO-22-103850

identified in some other adverse action. In December 2021, VA stated it does not have direct licensure oversight responsibilities for providers participating in Community Care Networks. Further, they stated that VHA Office of Community Care clinical staff are Credentialing Committee Review Board members and perform monthly and annual licensure audits on the providers within the Community Care Networks. VA officials also stated that providers who sign a VCA are certified and monitored for quality of care by both local VA medical center and Office of Community Care Credentialing.

### TPA Licensure Review Processes

We previously reported that when credentialing providers, TPAs may query the NPDB to identify actions that disqualify providers from participating in the Community Care Network.[36] However, TPAs were not contractually required to continuously monitor providers' licensure statuses. Specifically, one of the TPA's policies for reviewing license sanctions does not specifically require verification in states other than where the provider furnishes community care services. We found that neither TPA required a continuous monitoring process of providers' licensure sanctions in all states for all providers.

### We Identified Active Providers with Licensure Issues in PPMS

We analyzed NPDB matched files we received from HRSA and found that VHA and the TPAs did not exclude some providers with revoked or surrendered medical licenses. We provided HRSA with a list of 693,142 unique providers.[37] HRSA matched these providers to the NPDB and furnished 34,466 Adverse Action Report records, and 134 Judgments and Convictions Report records. We performed additional analysis on these records and identified providers with revoked or surrendered medical licenses who were listed as active in PPMS as of March 2020, including the following:

[36]GAO-21-71.

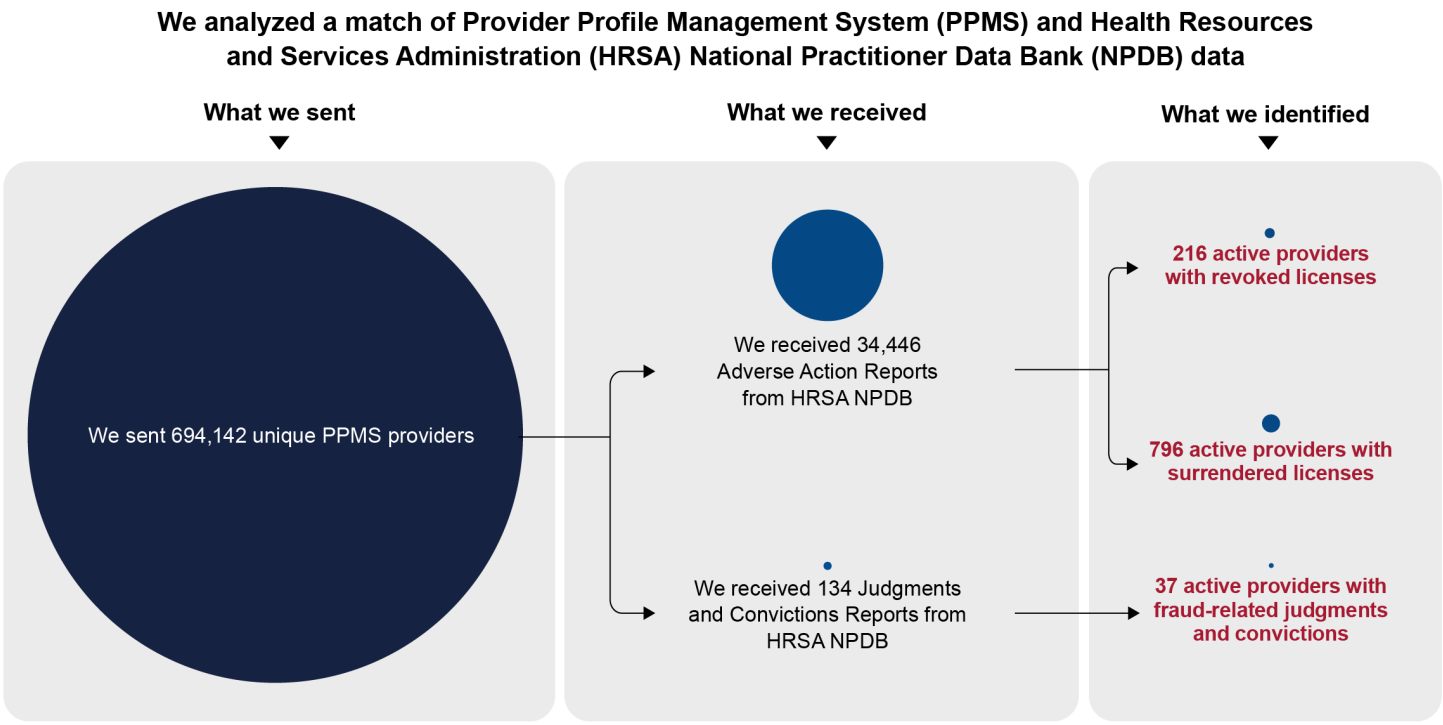
[37]We provided a smaller number of providers to HRSA for matching. We only provided HRSA with records for which we had SSNs. This resulted in a smaller file of unique providers for the agency to match.

- 216 providers with revoked licenses in the NPDB adverse action file;[38]
- 796 providers who had involuntary surrendered their licenses in the NPDB adverse action file;[39] and
- 37 providers who had a fraud-related judgment or conviction as of March 2021 in the NPDB judgments and convictions file.

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

[39]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 8: Results of PPMS and HRSA NPDB Data Analysis**

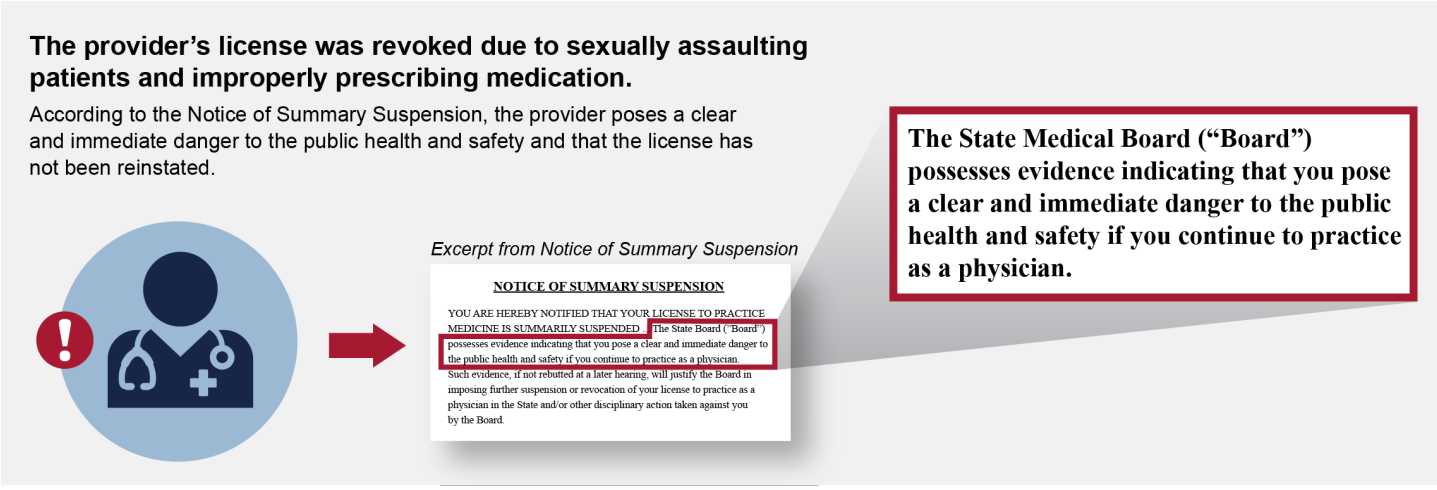



Source: GAO analysis of Department of Veterans Affairs and HRSA information | GAO-22-103850

For example, we identified a provider who was active in PPMS after his medical license had been revoked. A medical doctor had his license suspended by the 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 license had not been reinstated as of May 2021. The Drug Enforcement Administration also revoked the provider's registration, which means that the provider did not have the authority to prescribe or handle controlled substances.

VHA officials stated that the provider was available for service referrals in PPMS between 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. See figure 9 below.

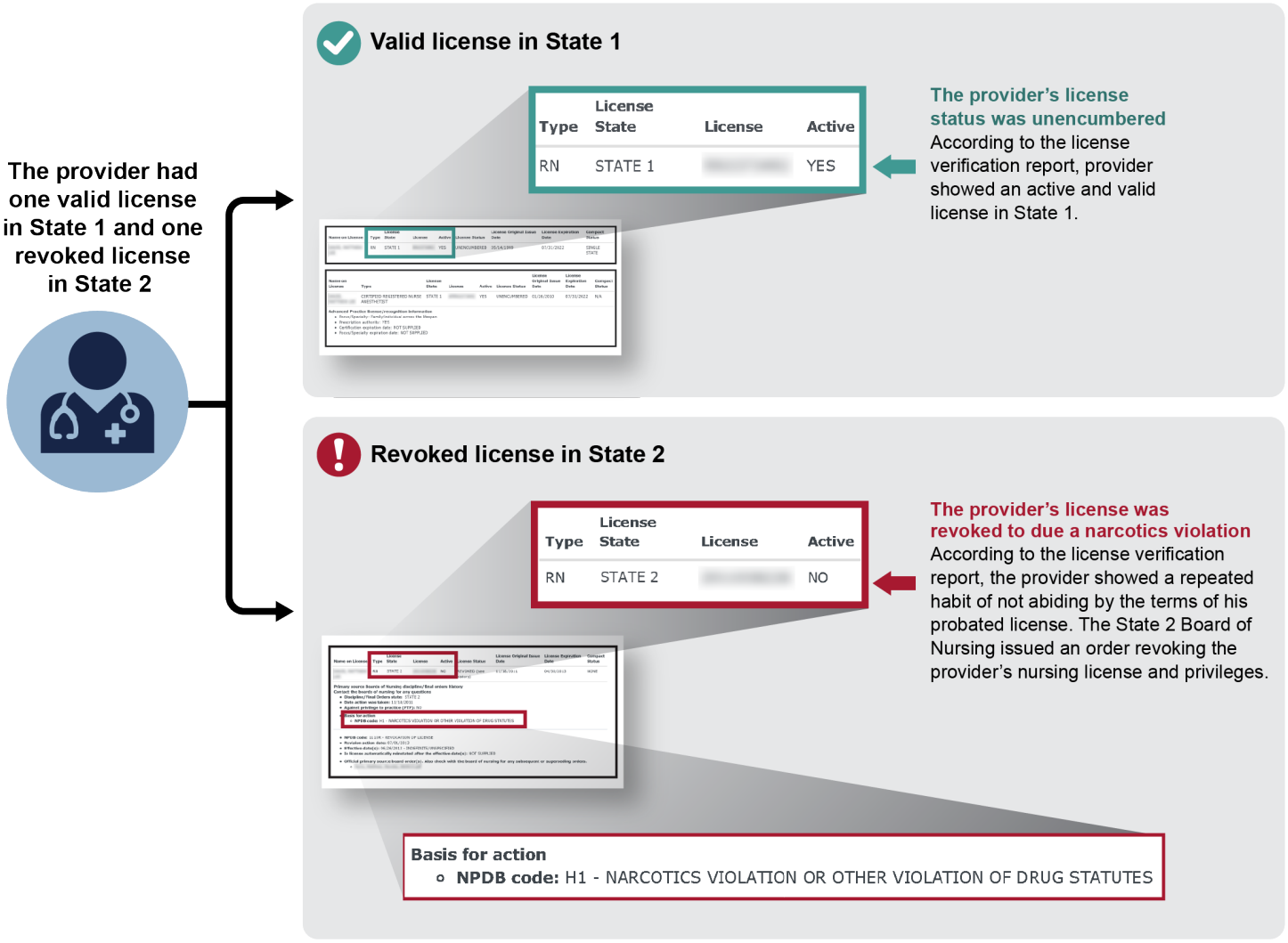
**Figure 9: Example of License Revocation**




Source: GAO review of medical licensure documentation. | GAO-22-103850

We also identified a provider who had lost his license in one state but held an active license in another state. Specifically, we found a certified registered nurse anesthetist had two licenses. One license, issued in State 1 in 1999, was unencumbered. However, a second license in State 2 was indefinitely revoked in 2013 for failure to meet the terms of license probation, which had been previously enacted for narcotics violations. Our analysis indicated that the provider was still active in PPMS as of July 2021. See figure 10 below.

**Figure10: Example of Revoked License Due to Probation Violation**




Source: GAO review of medical licensure documentation. | GAO-22-103850

## Prior GAO Reporting Identified Weaknesses with TPA Processes for Implementing VA MISSION Act Eligibility Restrictions

These findings are consistent with those of our February 2021 report on the TPAs' policies, which found that providers might not be consistently excluded from the participating in VCCP if they lost a state medical

license for violating the requirements of the medical license.[40] We made two recommendations in the February report to address these issues:

- The Secretary of Veterans Affairs, in concert with the Undersecretary for Health, should require the Community Care Network contractors to amend their 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 Veterans Community Care Program.
- The Undersecretary for Health should ensure that Community Care Network contractors 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 National Practitioner Data Bank's continuous query function.

VHA is in the process of implementing these recommendations. The recommendations, focused on improvements to provider licensure oversight, when implemented as intended, will help address some of the deficiencies identified in our analysis.

By not requiring the TPAs to regularly validate medical license statuses, VA puts veterans at risk of receiving care from unqualified providers, including some who lost their licenses for issues pertaining to safety and quality of work. Further, without comprehensive licensure reviews of community care providers, VA remains vulnerable to fraud committed by providers who have prior judgments or convictions related to fraud.

In our February 2021 report, we recommended that VA require its contractors to have credentialing and monitoring policies that ensure compliance with the VA MISSION Act license restrictions. These recommendations, once implemented, will help identify the providers who are potentially ineligible from participation in the VCCP.

## VHA's Address Verification Processes Did Not Detect Some Indicators of Potential 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. As such, VHA requires the TPAs to upload in PPMS each provider's full address, comprised of street number and name, city, state, and zip code. VHA officials stated that the scheduling system would not display data for providers if the full address was not available. However, VHA did not have specific requirements or guidance detailing how

[40]GAO-21-71.

practice locations should be verified and recorded in PPMS. Further, TPAs were not required to put in a location unit number, when applicable.[41] In December 2021, VA stated that VHA scheduling systems are not limited to one system and official appointment information for a veteran is ultimately managed within a separate internal program. VA officials also stated that if a full address is not available in PPMS, it will not prevent a referral from being scheduled. They also stated that a provider with an active service in PPMS with an assigned NPI is eligible for referrals regardless of an incomplete address.

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 reported that schedulers at VA medical centers had difficulties scheduling VCCP appointments because of issues with the quality of provider address data.[42] In that report, we interviewed staff at VA medical centers and reported issues with provider address data, including that staff stated providers did not know they were in the Community Care Network. VA officials stated that they had taken actions to address that the TPA did not update providers' addresses in PPMS after providers moved locations. We reported in September 2020 that VA and the TPA were working to address these issues.[43] In December 2021, VA officials stated that a healthcare service provider is expected to update their address information among all state and federal interfaces in which their data is housed. Further, VA officials stated that the professional onus for tracking a physical practice location to accept

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

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

[43]GAO-20-643.

patients is on the individual provider. Various forms of guidance on demographic updates are provided to the field or provider through TPAs.

As such, VHA Office of Community Care officials stated VA no longer performs address validation of provider addresses, but rather has an automated address confidence system that assists schedulers in selecting care site locations. This is a contractor software program that 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.

VHA has 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. The VHA Office of Community Care was not responsible for correcting provider addresses. Additionally, the TPAs rely on providers in their networks to notify them of changes to practice locations or statuses.

These are reactive measures, and the current process—which accepts provider address information at face value—is not designed to identify and prevent fraud and abuse. Preventive activities generally offer the most cost-efficient use of resources because they enable managers to avoid a costly and inefficient "pay-and-chase" approach.

According to federal internal control standards, managers should identify, analyze, and respond to risks.[44] 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.[45]

[44]GAO-14-704G.

[45]GAO-15-593SP.

To assess risks, managers should estimate the significance of a risk by considering the magnitude of impact, likelihood of occurrence, nature, and tolerance of the risk. Further, managers should document key findings and conclusions from these actions. The summation of these findings is defined as the program's "fraud risk profile". The fraud risk profile is an essential piece of an overall antifraud strategy.[46] Managers should design their overall risk responses for the analyzed risks based on the significance of the risk and defined risk tolerance captured in the risk profile.[47]

According to VHA Office of Community Care officials, VHA has not conducted such an assessment, which would better position it to design and implement risk-based preventive and other controls to manage these risks. As our prior work, noted below, and illustrative examples demonstrate, this has enabled providers to potentially defraud the VCCP.

Prior GAO work found that weaknesses in provider practice location verification may not prevent or detect ineligible or potentially fraudulent providers from enrolling in federal health care programs.[48] Specifically, our 2015 examination of practice location addresses of providers and suppliers listed in a Medicare system revealed thousands of questionable practice location addresses that federal regulations dictate must be operational. This work found that some providers' listed CMRAs, such as post office boxes, as their practice addresses, listing the post office box numbers as suite numbers with the street addresses. A provider intent on committing fraud could disguise a CMRA's address in this way to make the address look like an office suite. In our prior work, we identified two providers who had a United Parcel Service or similar store listed as a

[46]Magnitude of impact refers to the likely magnitude of deficiency that could result from the risk and is affected by factors such as the size, pace, and duration of the risk's impact. Likelihood of occurrence refers to the level of possibility that a risk will occur. The nature of the risk involves factors such as the degree of subjectivity involved with the risk and whether the risk arises from fraud or from complex or unusual transactions. The oversight body may oversee management's estimates of significance so that risk tolerances have been properly defined.

[47]Risk responses may include the following: (1) acceptance—no action is taken to respond to the risk based on the insignificance of the risk; (2) avoidance—action is taken to stop the operational process or the part of the operational process causing the risk; (3) reduction—action is taken to reduce the likelihood or magnitude of the risk; and (4) sharing—action is taken to transfer or share risks across the entity or with external parties, such as insuring against losses.

[48]GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers,* GAO-15-448 (Washington, D.C.: June 25, 2015).

practice location, which the CMS contractors inaccurately verified as an authentic practice location.

As part of that work, we recommended that CMS incorporate flags into its software to help identify potentially questionable addresses, revise its 2014 guidance for verifying practice locations, and collect additional license information to address fraud risks we identified. HHS agreed with our recommendation to modify CMS's software to include specific flags to help identify potentially questionable practice location addresses and implemented our recommendations.

Following a similar examination process as our prior work, we identified illustrative examples of provider addresses that did not meet the VHA requirement of being the physical location where veterans could receive care. We also identified instances where the physical address location was flagged as a CMRA, but we could not determine whether it was a legitimate practice location. This ambiguity may compound challenges we reported in September 2020 when scheduling veteran's appointments.[49]

Of the 826,101 providers in our PPMS data set, the USPS address-management tool returned a CMRA designation for 440 addresses.[50] We narrowed down the 440 addresses to a subset of 131 active providers that (1) had a single active address in the PPMS extract and (2) were the only active provider associated with that address. We performed an additional review on this selection of CMRAs to determine whether the PPMS practice address was either invalid (not a care site location), or valid (a care site location, such as a hospital).

Based on that analysis we determined that of the 131 potential CMRAs, 66 were invalid, and 38 were valid addresses.[51] We were unable to make a determination for the remaining addresses we reviewed.

[49]GAO-20-643.

[50]Based on USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. For example, a United Parcel Service store is a type of CMRA. Not all CMRAs are invalid practice locations. Our follow-up research identified examples of valid practice locations with this designation. For example, we identified a pharmacy located inside a grocery store that was flagged as a CMRA by the address-management tool.

[51]For our purposes, an invalid address is one where a provider could not be reasonably expected to provide a veteran with in-person care. Some of the address information available to the team for follow-up research was inconclusive. As such, we were not able to make a determination on the validity of these addresses.

## Conclusions

As part of an overall effort to enhance provider oversight controls, effective screening procedures are essential to ensure that ineligible providers do not participate in the VCCP. As the VCCP was launched, the VHA Office of Community Care implemented mechanisms to identify and remove ineligible providers from the VCCP. However, our analysis has identified five key vulnerabilities that may permit ineligible providers to participate in the program. First, VA's automated matches relied on using one variable to identify ineligible providers, which resulted in missing several ineligible providers that we identified using an additional variable. Second, delays in performing matches to exclusionary databases permitted ineligible providers to remain in the VCCP for months after they lost their eligibility to participate. Third, VHA did not follow its own documented procedures for screening providers to determine whether they should be excluded. Fourth, providers remained potentially eligible to participate in the VCCP after they lost a medical license, a factor that makes them ineligible to participate. Fifth, VHA did not have controls in place to flag potentially invalid practice location addresses, such as a CMRA.

Our examination of VCCP data showed that VHA Provider Exclusion Standard Operating Procedures were not followed. This permitted ineligible providers, identified in our review, to remain eligible to participate in the VCCP for months after they should have been excluded from the program. Our interviews with VHA Office of Community Care officials, coupled with our review of TPA documentation, indicated that VHA did not follow their own screening guidelines for monitoring community providers.

The vulnerabilities we identified in VHA's processes and our own examination of VCCP data indicate that veterans may potentially be at risk of receiving care from unqualified providers. Additionally, not excluding these providers put VHA at risk of fraudulent activity, as some of the providers we identified had previous convictions for health-care fraud. VA has an opportunity to take action and address these limitations as it continues to develop and refine the controls and policies and procedures for this 2-year old program.

## Recommendations for Executive Action

We are making the following ten recommendations to VA:

The Under Secretary for Health should ensure that Community Care Network contractors perform automated monthly checks for all VCCP providers against the HHS OIG LEIE using SSN, date of birth, and other unique identifiers. (Recommendation 1)

The Under Secretary for Health should ensure that the VHA Office of Community Care identifies and implements a process to inform schedulers of specific HHS OIG LEIE waiver specifications. (Recommendation 2)

The Under Secretary for Health should ensure that the VHA Office of Community Care revises 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. (Recommendation 3)

The Under Secretary for Health should ensure that the VHA Office of Community Care consults with the Administrator of the GSA to correct technical issues to ensure VHA can routinely monitor PPMS providers on the SAM Exclusions file. (Recommendation 4)

The Under Secretary for Health should ensure that the VHA Office of Community Care conducts automated matching of PPMS to LEIE, SAM, and NPPES in accordance with the monthly timeline outlined in its Provider Exclusion Standard Operating Procedures. (Recommendation 5)

The Under Secretary for Health should ensure that the VHA Office of Community Care identifies inherent fraud risks related to VCCP provider address controls. (Recommendation 6)

The Under Secretary for Health should ensure that the VHA Office of Community Care assesses the likelihood and impact of inherent fraud risks related to VCCP provider address controls. (Recommendation 7)

The Under Secretary for Health should ensure that VHA Office of Community Care determines the fraud risk tolerance related to VCCP provider address controls. (Recommendation 8)

The Under Secretary for Health should ensure that the VHA Office of Community Care examines the suitability of existing fraud controls related to VCCP provider address controls. (Recommendation 9)

The Under Secretary for Health should ensure that the VHA Office of Community Care documents the fraud risk profile related to VCCP provider address controls. (Recommendation 10)

## Agency Comments and our Evaluation

We provided a draft of this report to CMS, GSA, HHS OIG, HRSA, and VA for review and comment. We received technical comments from HRSA, HHS OIG, GSA, and VA, which we have incorporated as appropriate.

In its written comments, reproduced in appendix II, VA concurred with all ten recommendations, noting that the agency "concurred in principle" with recommendations one, two, and three. VA further noted that it had taken action to implement recommendation four. VA concurred with recommendations four, five, six, seven, eight, nine, and ten, and described its plans for implementing them.

- For recommendation one, ensuring that Community Care Network contractors perform automated monthly checks for all VCCP providers against the HHS OIG LEIE using SSN and DOB, VA stated it agreed in principle because SSNs and DOB are not accessible identifiers for all providers. VA stated that it will add LEIE validation as a deliverable component of the Credentialing Audit reviews to ensure a monthly check occurs for all VCCP providers. We agree that this action, once implemented as intended, will help ensure that VCCP providers are checked against the LEIE in a timely fashion.

- For recommendation two, ensuring that the VHA Office of Community Care identifies and implements a process to inform schedulers of specific HHS OIG LEIE waiver specifications, VA stated that it concurred in principle but does not believe the solution lies with individual schedulers. VA stated that the Office of Community Care will conduct manual data updates in PPMS based on the geographical area of an approved waiver. We agree that this proposed solution, once implemented as intended, will help address the issues identified in our report.

- For recommendation three, ensuring that the Office of Community Care revises 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. VA expressed concern that the Office of Community Care could exclude an entire organization if TIN were used for validation. Further, VA stated that it had completed its work on this recommendation and asked GAO to consider closing it. As mentioned in our report, VHA's current Standard Operating Procedures, as written, require VHA to use TIN for SAM validation. We are recommending that VHA use NPI in addition to

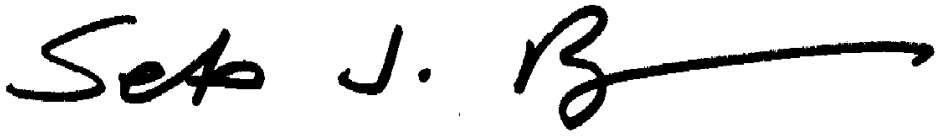
TIN, which VHA already uses, to identify these potentially ineligible providers. Further, in September 2021, we requested evidence from VA that its new process for addressing this recommendation was successfully implemented. While VA provided process-related documents, dated August 2021, for how this process is intended to work, the agency did not provide evidence that the process was successfully implemented and operational. Accordingly, we are not closing this recommendation at this time, but we will continue to work with VA to verify the actions taken in response to this recommendation.

- In concurring with recommendation four, VA stated that the agency already implemented its plan to address the recommendation. In September 2021, we requested evidence from VHA that this plan was successfully implemented. While VA provided process-related documents dated August 2021, for how this process was designed, the agency did not provide evidence that the plan was successfully implemented and operational. Accordingly, we are not closing this recommendation at this time, but we will continue to work with VA to verify the actions taken in response to this recommendation.

As agreed with your offices, unless you publicly announce the contents of the report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov or Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page

of this report. GAO staff who made major contributions to this report are listed in appendix III.



Seto J. Bagdoyan
Director of Audits, Forensic Audits and Investigative Service

Sharon M. Silas
Director, Health Care

# Appendix I: Objectives, Scope, and Methodology

To identify the extent to which potentially ineligible providers are participating in the VCCP, we compared provider data from VHA's Provider Profile Management System (PPMS) to several exclusionary datasets. We performed this analysis to determine whether any providers who were ineligible to provide community care were currently participating in the Veterans Community Care Program (VCCP).[1] To do this, we requested PPMS data from the Office of Community Care on unique providers, by National Provider Identifier (NPI), current as of March 2020. The extracts we received contained 3,636,589 records, for 826,101 unique providers. We requested that the PPMS data extract be inclusive of individual providers and organizations in an active, inactive, revoked, or suspended status.

We matched providers in these datasets using unique identifiers, either Social Security Number (SSN), Tax Identification Number (TIN), or NPI. However, we were limited in our ability to identify the full extent to which ineligible providers were active providers in PPMS due to limitations of PPMS extraction capabilities. Office of Community Care officials told us they could not provide a complete dataset for the entire population of community providers in PPMS due to data extraction issues encountered by VHA contractors when transferring data from PPMS to the VA Commercial Data Warehouse, including limitations on the amount of data that can be extracted at one time—100,000 rows of data. Specifically, officials said they encountered issues filtering the data when importing information to the VA Commercial Data Warehouse from PPMS. As a result, there may be additional providers participating in the VCCP who are not included in our analysis, and our results may be understated. Officials said they are working to resolve this issue by pulling data into another system to allow for easier and more complete extraction in the future.[2]

[1]According to VHA, PPMS is VHA's master database of community providers, including those connected to the Community Care Network and those with a Veterans Care Agreement (VCA), and was deployed nationally at the end of fiscal year 2018. PPMS receives and stores information about each provider such as provider name, the types of services the provider is authorized to deliver, the provider's credentialing status, the date the provider is due to be re-credentialed, and whether the provider is excluded from VCCP participation. According to VHA officials, within PPMS, providers are identified by their National Provider Identifier, which is a unique 10-digit number issued to health care providers in the United States by the Centers for Medicare & Medicaid Services.

[2]As of October 2021, VHA Office of Community Care officials had not resolved these issues with their contractors.

We identified some additional limitations to the data that may yield understated results. Specifically, because SSNs are not stored in PPMS, we obtained this information for our providers from the National Plan and Provider Enumeration System (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. Not all of the providers in PPMS had a SSN on file with the NPPES NPI registry, which limited our ability to match these providers to some of our exclusionary data sources. The NPPES registry may not have a SSN for providers because the NPI is an organization NPI, so an SSN was not stored, the NPI was incorrect in PPMS, or in a small number of cases the NPPES system did not have an SSN stored for an individual. For example, we identified one individual without an SSN in the system, and further research showed that this individual was a foreign-born provider, legitimately providing care in the US, and as such did not have an SSN. Due to these factors, the results of our aggregate analysis may be understated.

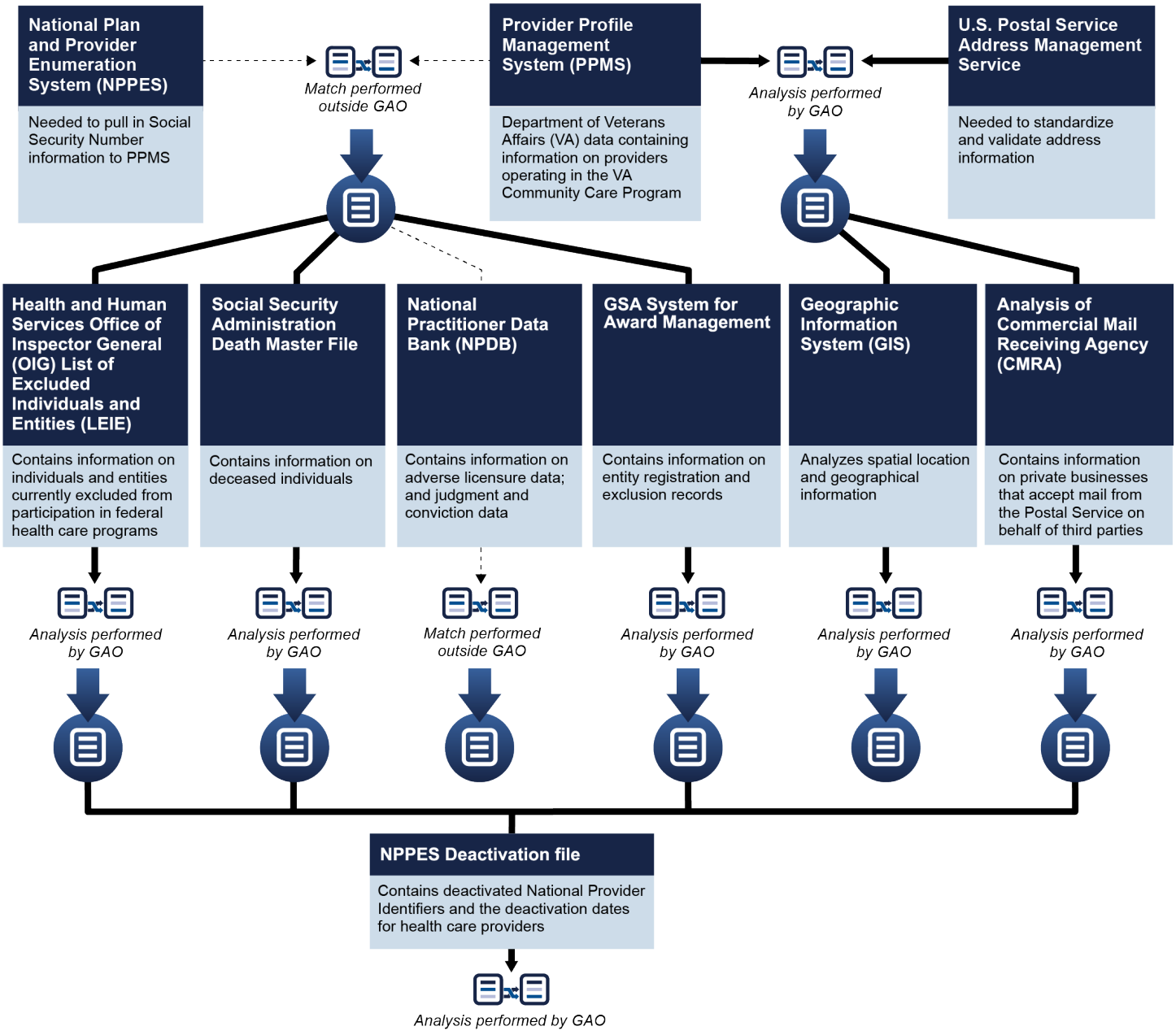
We matched the PPMS extract of providers to the following exclusionary data sources. To identify potentially ineligible VCCP providers who:

- should be excluded based on VHA standard operating procedures and VHA contracts with the TPAs, we matched providers with the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE), the U.S. General Services Administration System for Award Management (SAM) Exclusions file, and the NPPES NPI deactivation file;
- are deceased and physically unable to provide care, we matched our PPMS provider dataset with the Social Security Administration (SSA) Death Master File;
- should not be participating in VCCP according to VA MISSION Act provisions because they have medical licenses that have been revoked or surrendered and have not been reinstated, we matched our PPMS provider dataset with the U.S. Health Resources and Services Administration National Practitioner Data Bank (NPDB) adverse action licensure reports; or
- have practice locations that may not comply with VCCP requirements, we matched provider address information from PPMS to United States Postal Service data. We used the results of this match to identify examples of addresses that appeared to be mailboxes at postal stores, where a veteran would be unable to receive care from a VCCP provider. We also used address data to identify practice

locations that were located outside of the Community Care Network listed in PPMS.

We requested VCCP claims information for all providers we identified in our LEIE, SAM, and SSA Death Master File matches. We also obtained claims data for all providers we selected for additional review, including providers with questionable NPIs or addresses. We assessed the reliability of all the data used in our analysis by reviewing relevant documentation, interviewing knowledgeable VHA officials, and performing electronic tests. We determined that the eight data sources we analyzed were sufficiently reliable for the purposes of our audit objectives. Please see figure 11 below for additional information on our data match process.

**Figure 11: GAO Process for Matching PPMS Providers to Screening Data Sources**




Source: GAO. | GAO-22-103850

To determine what vulnerabilities may have permitted ineligible providers to participate in VCCP, we performed an in-depth review of 88 providers to serve as illustrative examples. Table 1 outlines the number of matches and the number of providers selected from each analysis.

**Table 1: Number of Providers Selected for Case Studies, by Analysis Category**

| Analysis category | Number of providers | Total selected for case study |
|---|---|---|
| Providers on the Department of Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities | 57[a] | 38 |
| Providers on the General Services Administration System for Award Management Exclusions file list not excluded by HHS OIG. | 151[b] | 11 |
| Individual providers for whom our match with NPPES data did not provide a SSN | 195 | 3 |
| Providers listed on the Social Security Administration Death Master File | 1,069 | 16 |
| Potential commercial mail receiving agencies listed as addresses | 440 | 13 |
| Addresses listed outside of a provider's reported region | 27 | 7 |
| **Total** | **1,935** | **88** |

Source: GAO analysis of various data sources. | GAO-22-103850

[a]This number includes fuzzy matches by name and location. Our case study work determined the fuzzy matches were not valid matches.

[b]This number includes fuzzy matches by name and location. Our case study work determined the fuzzy matches were not valid matches.

For our HHS OIG LEIE matches, we selected providers who met one of the following criteria: matched on SSN or TIN, but did not match on NPI, or had the same listed city and state and the same or similar names (i.e., "fuzzy matched"). and specialties, matched on NPI and were excluded prior to March 2020 (the earliest "as of" date for our PPMS data), but remain active in the data and matched on NPI, were excluded in March 2020 or later, and were active in the data.

For our SAM Exclusions matches, we selected providers who matched using NPI, or had the same listed city and state and the same or similar names (i.e., "fuzzy matched").

We selected individual providers for whom our match with NPPES data did not provide a SSN who either had a practice location on the NPPES

registry listed outside of the United States or were potentially on the LEIE based on match of name and specialty.

For our SSA Death Master File matches, we judgmentally selected providers who billed for VCCP services rendered after the date of death. We also selected active and inactive Community Care Network and VCA providers, as well as active and inactive non-VCCP providers, such as those from the Patient-Centered Community Care and Choice networks.

For providers we identified with CMRAs listed as practice locations, we judgmentally selected 13 providers to review using criteria including: providers whom we would expect to have a physical office to render care, addresses that merited follow-up based on a comparison with NPPES registry address information, and addresses that appeared to be invalid based on a review of corroborating information.

# Appendix II: Comments from the Department of Veterans Affairs

**DEPARTMENT OF VETERANS AFFAIRS**
**WASHINGTON**

December 6, 2021

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report, ***Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*** (GAO-22-103850).

The enclosure contains technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to the
Government Accountability Office (GAO) Draft Report
***Veterans Community Care: VA Should Strengthen its Ability to Identify Ineligible Health Care Providers***
(GAO-22-103850)

**Recommendation 1: The Under Secretary for Health should ensure that Community Care Network contractors perform automated monthly checks for all VCCP providers against the HHS OIG LEIE using SSN, DOB, and other unique identifiers.**

**VA Response:** Concur in principle. The Veterans Health Administration (VHA) Office of Community Care (OCC) will continue to require the List of Excluded Individuals and Entities (LEIE) reviews from the Community Care Network (CCN) contractors. Exclusion validation is critical to the mission of OCC. LEIE reviews are included as a requirement within the CCN contracts. OCC concurs in principle because social security numbers and date of birth are not accessible identifiers for all providers and are dependent on the provider's licensed independent practitioner status. OCC agrees that the assurance of LEIE validation performance by the CCN Contractors is vital and will add LEIE validation as a deliverable component of the Credentialing Audit reviews to ensure a monthly check occurs for all Veterans Community Care Program (VCCP) providers.

Target Completion Date: February2022

**Recommendation 2: The Under Secretary for Health should ensure that the VHA Office of Community Care identifies and implements a process to inform schedulers of specific Health and Human Services Office of Inspector General LEIE waiver specifications.**

**VA Response:** Concur in principle. OCC agrees that restriction of individual providers versus restriction of a geographic location has limitations but does not believe the solution lies with individual schedulers. Instead, OCC will conduct manual data updates in the Provider Profile Management System (PPMS) based upon the geographical area of an approved wavier. This procedure will allow the service for an approved waiver to be active, while deactivating any services that do not fall within the waiver. Schedulers will be able to view the status when searching for a potential provider.

Target Completion Date: February 2022

**Recommendation 3: The Under Secretary for Health should ensure that the VHA Office of Community Care revises 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 Response:** Concur in principle. OCC agrees the System for Award Management (SAM) matching is an integral part of OCC's exclusion procedure. OCC will continue to

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follow current procedures using National Provider Identifier (NPI) as an identifier. The NPI is tied to the individual as opposed to the entire organization. VA is concerned OCC could exclude an entire organization if a Taxpayer Identification Number (TIN) is used for SAM validation versus the respective NPI. There is an exponential impact on access to care if an organization, such as a large hospital system, is deactivated using the TIN versus using the NPI of a provider who may work within that hospital system. A new SAM validation process was developed in PPMS in September 2021. The SAM website is checked daily and when a new update is available PPMS imports the update. After the update is imported, PPMS validates any providers within the update against providers who are already in PPMS. PPMS uses the NPI within these updates to process any matches.

VHA has completed its work on this recommendation and asks GAO to consider closure.

**Recommendation 4: The Under Secretary for Health should ensure that the VHA Office of Community Care consults with the Administrator of the U.S. General Services Administration to correct technical issues to ensure VHA can routinely monitor PPMS providers on the SAM Exclusions file.**

**VA Response:** Concur. Correcting technical issues related to monitoring providers is invaluable to OCC mission and operations. OCC developed and implemented a new automated process to address technical issues associated with SAM validations. A new SAM automated validation process was developed in September 2021. The SAM website is checked daily for updated information. If an update is available, PPMS imports the update and validates providers against providers in PPMS. SAM and PPMS use the NPI to complete the process. OCC is confident that the above-mentioned correction will ensure routine monitoring of providers on the SAM exclusion file and requests closure of this recommendation.

VHA has completed its work on this recommendation and asks GAO to consider closure.

**Recommendation 5: The Under Secretary for Health should ensure that the VHA Office of Community Care conducts automated matching of PPMS to LEIE, SAM, and NPPES in accordance with the monthly timeline outlined in its Provider Exclusion Standard Operating Procedures.**

**VA Response:** Concur. OCC takes the Provider Exclusion Management (PEM) process seriously. OCC will ensure that automated matching occurs in accordance with the PEM Standard Operating Procedure (SOP). The PEM process has been an ongoing priority and has undergone multiple revisions to accurately account for correct procedure and protocol, as well as to align with technical updates made within the systems and databases applicable to the process. OCC has continuously revaluated steps and explanations within the SOP to mirror PPMS operations and functionality. The PEM SOP will be updated to include the correct frequency of LEIE, SAMS and NPPES.

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Target Completion Date: December 2021

**Recommendation 6: The Under Secretary for Health should ensure that the VHA Office of Community Care identifies inherent fraud risks related to VCCP provider address controls.**

**VA Response:** Concur. OCC committedly agrees that an inherent fraud risk related to address controls should be assessed and benchmarked per industry standard. It is the intent of OCC to proactively mitigate any identified risks. OCC will conduct a risk assessment to identify inherent fraud risks related to VCCP provider address controls.

Target Completion Date: July 2022

**Recommendation 7: The Under Secretary for Health should ensure that the VHA Office of Community Care assesses the likelihood and impact of inherent fraud risks related to VCCP provider address controls.**

**VA Response:** Concur. OCC agrees that the likelihood and impact of the inherent fraud risk related to address controls should be assessed. OCC will conduct a risk assessment to assess the likelihood and impact of inherent fraud risks related to VCCP provider address controls.

Target Completion Date: July 2022

**Recommendation 8: The Under Secretary for Health should ensure that the VHA Office of Community Care determines the fraud risk tolerance related to VCCP provider address controls.**

**VA Response:** Concur. OCC agrees that fraud risk tolerance related to address controls should be assessed and benchmarked. OCC will conduct a risk assessment to determine fraud risk tolerance related to VCCP provider address controls.

Target Completion Date: July 2022

**Recommendation 9: The Under Secretary for Health should ensure that the VHA Office of Community Care examines the suitability of existing fraud controls related to VCCP provider address controls.**

**VA Response:** Concur. OCC agrees that OCC should examine existing fraud controls related to VCCP provider address controls. OCC will conduct a risk assessment to identify and assess existing fraud controls related to VCCP provider address controls.

Target Completion Date: December 2022

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**Recommendation 10: The Under Secretary for Health should ensure that the VHA Office of Community Care documents the fraud risk profile related to VCCP provider address controls.**

**VA Response:** Concur. OCC agrees to assess and document the fraud risk profile related to VCCP provider address controls. Once the risk assessment is complete, the fraud risk profile related to VCCP provider address controls will be documented.

Target Completion Date: December 2022

# Appendix III: GAO Contacts and Staff Acknowledgments

## GAO Contacts

Seto J. Bagdoyan, (202) 512-6722 or BagdoyanS@gao.gov

Sharon Silas, (202) 512-7114 or SilasS@gao.gov

## Staff Acknowledgments

In addition to the contacts named above, Dean Campbell (Assistant Director), James Ashley, Priyanka Sethi Bansal, Julia DiPonio, Kristina Hammon, Marcia Mann, Eve Nealon, Sabrina Streagle, Ashni Verma, and Erin Villas made key contributions to this report. Other contributors include Carrie Davidson, Ranya Elias, Colin Fallon, Barbara Lewis, Maria McMullen, Jason Palmer, Stacy Spence, Adam Windram and April VanCleef.

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Washington, DC 20548

## Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
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