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OFFICE OF INSPECTOR GENERAL FOR THE
US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
US SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
"BUILDING A 21ST CENTURY VA HEALTH CARE SYSTEM: ASSESSING THE NEXT GENERATION OF VA'S COMMUNITY CARE NETWORK"
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Chairman Moran, Ranking Member Blumenthal, and committee members, thank you for the opportunity to discuss the oversight conducted by the Office of Inspector General (OIG) related to the contracts governing the community care network. Meeting veterans' healthcare needs requires VA to support and coordinate highly skilled multidisciplinary clinical teams that prioritize the quality and timely delivery of direct care. That mandate to provide prompt and exemplary services becomes more complex when VA refers veterans to community care. In keeping with our mission, the OIG's Office of Healthcare Inspections and our Office of Audits and Evaluations provide comprehensive oversight of Veterans Health Administration (VHA) programs and services. Our Office of Investigations works with data analytics and other teams to identify and address healthcare fraud and other related crimes.

It is important to acknowledge that OIG personnel regularly observe dedicated VA staff providing veterans with needed direct care and services, as well as acting in veterans' best interests when referring them to care in the community. As VHA executes its plans for reorganization, which may reshape aspects of the community care program, the OIG will continue to monitor actions that affect patient safety; the provision of timely, high-quality care; compliance with laws and governing standards; and the efficient and effective use of taxpayer dollars.

The OIG has reported on challenges with the current community care program contracts. The recent announcement of the Community Care Network Next Generation solicitation presents an opportunity for VA to learn from prior oversight and to develop a contract grounded in best practices. VA is already taking some steps in that direction. The OIG's initial review of the contract solicitation found positive developments in medical documentation return requirements, which can help prevent and detect fraud and improve continuity of care. While 50 of the 63 community-care-program-focused recommendations contained in the OIG reports discussed in this statement are now closed, they represent areas of

vulnerability for VA in contract management. Specifically, the issues that those recommendations addressed could reemerge, particularly in new or amended contracts.

Prior OIG reports on VA's management of the contracting and business aspects of the community care program have consistently found that (1) VHA struggles to ensure veterans experience timely, seamless coordinated care when they are referred to the community; (2) VHA cannot be certain of the quality of care that community providers deliver; (3) workforce challenges and insufficient VHA controls for managing community care exacerbate coordination problems; and (4) outdated or inadequate information technology systems, as along with inaccurate and incomplete data, significantly restrict VA's ability to manage community care payments.[1]

The information that follows spotlights OIG findings and recommendations related to the management and oversight of the current contract. In addition, it outlines provisions the OIG proposes should be considered for inclusion in the next generation of contracts to maximize the use of taxpayer funds and ensure veterans receive high quality, timely care from community providers.

VA'S MANAGEMENT OF THE THIRD-PARTY ADMINISTRATORS' PERFORMANCE IN ADMINISTERING THE COMMUNITY CARE NETWORKS

The OIG has regularly reported on the clinical and administrative challenges VA, VHA's Office of Integrated Veterans Care (IVC), and individual VA medical facilities face in managing the community care program. VA has third-party administrators (TPAs) to oversee community care provider adherence to the contracts, and the OIG previously found both TPA oversight and provider adherence to the contracts lacking. In addition, VA has not consistently followed its own processes when administering the program and coordinating clinical care for veterans.

Obtaining and Importing Community Care Documents into the Patient's VA Electronic Health Record Facilitates Care and Fraud Prevention Efforts

VHA clinicians have emphasized that prompt receipt of community care medical records is crucial for care coordination and quality of care oversight.[2] Delays in sending medical records can also compromise efforts to combat fraud. Many VA leaders reported problems receiving records from community providers and long lag times from the facility's receipt of those records to when VA facility staff scanned them into the patient's record. VHA policy requires that all internal and external documents be imported into the electronic health record within five business days of receipt from the provider. VHA staff have identified technological limitations as contributing causes to providers' lapses in sending records, such as the reliance on electronic faxes and complexity in using the web-based portals. At the same time, VHA staff attributed limited time and personnel to scanning backlogged records. The lack of

[1] All OIG reports filtered to highlight VA's community care program can be found on the website.
[2] VA OIG, *Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records*, August 7, 2025.

coordination also burdens VHA clinicians and staff who must divert attention from patient care to chasing down records.

VA's Oversight of Opioid Prescriptions and Special-Authorization Prescriptions Written by Community Care Providers

Veterans are at an elevated risk of opioid overdose, often due to higher rates of chronic pain and co-occurring mental health conditions, such as those associated with posttraumatic stress disorder and military sexual trauma.[3] When veterans receive care in the community, opioid prescriptions must be tracked and coordinated with VA. The MISSION Act of 2018 requires VA to ensure that community providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.[4] By contract, VA also requires providers to query state prescription drug monitoring programs to determine if a veteran has existing opioid prescriptions before issuing a new one. In two reports, the OIG found nonadherence with these requirements at facility and national levels.[5] Based on VA's corrective actions, the recommendations from these reports are now closed; however, community opioid prescribing practices pose a risk to veterans that the OIG continues to monitor.

Additionally, in 2024, the OIG found that VA and the TPAs were not ensuring that community care providers submitted contract-required justifications for initial prescriptions of special-authorization drugs, partly because the IT system lacked the needed capabilities, requiring provider work-arounds.[6] VHA reported workforce issues because of the increasing number of community care prescriptions processed in VHA-operated pharmacies that required work-arounds. The OIG found the processing often exceeded VHA's four-day standard, averaging about 11 days. VHA also did not hold TPAs accountable for ensuring community providers followed procedures. Less than 2 percent of community providers completed the TPA-developed training. The OIG questioned about $200 million in prescription costs that lacked justification from community providers. The report had seven recommendations, now closed, to improve community providers' prescribing compliance, system capabilities, training adherence, VA pharmacies' documentation of justifications, and the clarity of requirements for VA pharmacies to report noncompliant community providers.

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[3] John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020); VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022.

[4] P.L. 115-182, The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.

[5] VA OIG, *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth*, September 26, 2023; VA OIG, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, September 26, 2023.

[6] VA OIG, *Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times*, August 15, 2024.

Community Care Provider Requests for Additional Services

When community care providers evaluate VA patients, they may identify additional care needs that were not in VA's referral. The provider can send a request for additional services back to VA for approval. However, OIG teams have found VA community care staff do not consistently process the requests within the required three business days of receiving the referral.[7] These delays, along with failures to properly document or notify providers of denials, can hinder follow-up care for veterans.

VA's Oversight of TPA Performance and Provider Network Adequacy

VHA must oversee the TPAs' administration of the community care provider program, including ensuring the TPA's healthcare provider networks are robust enough to provide timely services to veterans. The OIG found that IVC did not hold the TPAs accountable for contract requirements designed to ensure facilities have enough community providers to administer care within timeliness and drive-time standards. As a result, facility staff struggled to convince the TPAs to build up the network. IVC also did not analyze facilities' network adequacy to help inform the TPAs of the need to expand provider networks and did not ensure the TPAs maintained provider networks that accepted VA patients. The OIG recommended that IVC hold future TPAs accountable for operational readiness and provider network adequacy, and that IVC develop processes to update and maintain community care network data, challenges, and needs. The improvements VHA made in performance measurement that enabled these recommendations to be closed should be considered for inclusion in the next generation contract.[8]

In a 2025 audit, the OIG examined whether VHA made accurate and timely community care payments for outpatient healthcare and dental services.[9] The OIG estimated that although error rates were small, the combined estimated errors resulted in overpayments of about $178.5 million because VHA did not charge the correct Medicare rate or applicable VA fee rate in cases for which VHA lacked an established contractual rate, resulting in payments at invoiced amounts.

Additionally, the OIG estimated that VHA paid over $900 million more to both TPAs combined than the TPAs paid community providers for dental services. About $650 million resulted from a VA contracting error caused by an incorrect pricing spreadsheet being incorporated into contracts that went undetected during VA oversight reviews. This contracting error has been corrected, and the corresponding VA OIG recommendation is closed. Other recommendations called on VHA to prevent and recover overpayments in timely manner and to work with the Office of Acquisition, Logistics, and Construction so healthcare invoices are monitored by the appropriate staff. Additionally, four of the five community care regions

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[7] VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*, July 29, 2025.
[8] VA OIG, *Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance*, April 9, 2024.
[9] VA OIG, *Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*, February 20, 2025.

did not cap VHA's dental reimbursements to TPAs at provider invoice amounts; the recommendation to address this issue remains open.

NEW CONTRACT PROVISIONS COULD ENHANCE THE COMMUNITY CARE PROGRAM

In addition to providing VA with actionable recommendations to improve the community care program, the OIG has engaged with VA about provisions that can be inserted in the next generation contract to improve oversight, fraud detection, contract compliance, program efficiency, and healthcare delivery.

- **To support statutory independent oversight, the OIG should be able to obtain requested documentation of care from the TPAs without a subpoena.** Under the IG Act and other authorities, the OIG may subpoena testimony and documents from entities and individuals, regardless of their contractual relationship with VA or the TPAs. The next generation contract should require contracted entities to provide documents to the OIG without a subpoena and notify all entities of that mandate. This will more efficiently enable the OIG to examine concerns about the quality of community care and potential fraud.
- **To help deter fraud, the TPA should be required to include in all healthcare provider agreements a standardized notice of providers' obligation to comply with federal laws and the consequences for nonadherence.** Healthcare providers are already subject to a similar standard contract provision when applying for reimbursement from the Centers for Medicare & Medicaid Services. Tailoring it to VA contracts, it could include language such as:

  > In submitting any claim for payment to a TPA for reimbursement from VA, the healthcare provider certifies that the services were medically indicated and necessary to the health of the patient and were personally furnished by the provider or their employee under their direction. Provider understands that its claim will be reimbursed from Federal funds and any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal laws.

- **Enforcement provisions should be included for provider noncompliance with record-sharing requirements, and inpatient facility incentives considered to periodically update VA on treatment.** Given VA's difficulties in receiving records from community care providers, it should consider an enforcement mechanism for community care facilities and providers that fail to provide records as required. Ideally, inpatient facilities could also be incentivized to provide ongoing treatment updates and plans to VA during a veteran's treatment.
- **Community care providers should be incentivized to meet the same training and quality standards as VA providers.** The OIG has found that the TPAs could not account for whether community providers completed training on specific medication ordering and opioid-prescribing checks. VA and TPAs should be encouraged to identify ways to maintain an accurate database of provider training (accounting for frequent changes to network participants). Additionally, the OIG would welcome a requirement for provider training on their obligation to cooperate with the OIG.

- **The TPAs should be incentivized to follow fee schedules.** To consistently control costs and avoid TPA overpayments, a contract provision could address the need to follow any VA-established fee schedules for specified medical services. As an example of this need, the OIG's recent management advisory memo on community substance use disorder treatment facilities noted that VHA completed a contract modification with only one of the two TPAs to implement a fee schedule for this care, which resulted in significant overpayments.[10]
- **Improved oversight of referral processes and quality reviews can strengthen veteran care.** To increase assurances that veterans referred to the community are receiving health care that meets VHA's quality standards, VHA should consider contract provisions that provide additional checks on provider credentialing and ongoing competence as well as quality reviews of patient safety reporting and follow-up. Delegating contractor performance oversight to another contractor weakens the government's ability to know it is receiving the services it purchased. In addition to raising the quality of care, including these provisions may further facilitate anti-fraud efforts and reduce duplicative and unnecessary care, leading to higher patient satisfaction and lower costs.

CONCLUSION

The OIG is focused on its mission to conduct independent oversight of VA to provide findings and recommendations that help VA use its resources to efficiently provide veterans with benefits and services. The next generation community care contract provides VA an opportunity to make improvements that draw from lessons learned from implementing prior OIG recommendations and addressing risks identified in oversight reports. VA contracting and program officials should engage industry and other stakeholders to help create a robust community care network that increases access for veterans. Failures in monitoring, quality reviews, compliance enforcement, program management, and other issues raised in OIG reports risk cascading problems that can affect patient safety and care and undermine efforts to protect VA against fraud, waste, and misuse of resources meant to improve healthcare services to veterans and support the providers who serve them.

Chairman Moran, Ranking Member Blumenthal, and members of the committee, this concludes my statement. The OIG looks forward to working with Congress to advance VHA's provision of care to veterans, regardless of where it is delivered. I would be happy to answer any questions you may have.

[10] VA OIG, *Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans*, September 17, 2025.