DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program

AUDIT | REPORT #20-02828-174 | AUGUST 4, 2021

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Executive Summary

Because older veterans may live alone, experience isolation, or cope with multiple health conditions, the Veterans Health Administration (VHA) provides a wide range of long-term services, including geriatric outpatient programs, home and community-based long-term support, and end-of-life care. The Veteran-Directed Care (VDC) program, one of VHA's 12 noninstitutional care programs, provides veterans with a budget to hire caregivers and purchase the goods and services that will best meet their care needs and allow them to remain in their homes longer.[1] According to VHA, the VDC program is ideal for veterans who live in remote and rural areas where homemaker and home health aide services are difficult to obtain.[2]

VHA's Office of Geriatrics and Extended Care administers the VDC program to maximize veterans' functional independence and prevent or lessen the burden of disability on older, frail, and chronically ill patients, their families, and caregivers.[3] While medical facilities have the option to implement the VDC program, it is not available at all facilities. Once VHA deems a veteran eligible for the program, VHA personnel determine their budget and purchase care from a provider agency. Provider agencies are responsible for helping veterans with developing program spending plans, educating and supporting veterans on employing caregivers, providing financial management services, and conducting ongoing monitoring of the services provided to veterans.[4] The veteran manages their own budget to include purchasing items and services, and the provider agency charges VHA an administrative fee for coordinating services.

VHA guidance does not identify the position that is charged with carrying out VDC program responsibilities on behalf of the facility. The guidance sometimes refers to a VHA medical facility, facility personnel, or a program coordinator. Furthermore, the guidance also does not detail if the program coordinator should have clinical or administrative qualifications or maintain these responsibilities full-time or have them assigned as a collateral duty.

Since fiscal year (FY) 2017, the VDC program has grown significantly. The number of veterans in the program has more than doubled, to about 4,400 in FY 2020. During this time, VDC program expenditures have increased by about 97 percent. The Office of Inspector General (OIG) conducted this audit to determine if VHA budgets and manages

[1] VA's noninstitutional care is provided in an outpatient or home setting.

[2] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016. VHA pays for homemaker and home health aide services to help eligible frail or disabled veterans take care of themselves and manage their daily activities.

[3] VA, "Geriatrics and Extended Care Program," accessed March 3, 2021, https://www.patientcare.va.gov/geriatrics.asp.

[4] VHA, National Non-VA Medical Care Program Office, *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*. The audit team confirmed with VHA personnel that this document was dated July 21, 2017.

VDC resources to ensure veterans in the program receive authorized goods and services to help them remain in their homes.

What the Audit Found

The OIG found that VHA provided VDC services to veterans that addressed their care needs. However, due to weaknesses in program management, VHA lacks assurance that veterans in the program are being monitored properly, provider agencies are paid correctly, and taxpayer dollars are properly spent. In addition, the team identified opportunities for VHA to improve VDC policies and funding to ensure medical facilities can effectively implement and manage the program to help veterans stay in their homes.

VHA Provided VDC Services to Veterans That Addressed Their Care Needs, but Program Management Needs Improvement

Overall, VDC program controls are in place and working to ensure veterans receive VDC services in accordance with their needs. All 68 randomly selected veterans reviewed had spending plans that matched the level of care determined by VA and provider agencies documented the spending plans, which were within the authorized budgets.

However, while provider agencies monitored all veterans as required, the audit team could not confirm VDC program personnel monitored an estimated 40 percent of veterans (1,600 of 4,100).[5] VDC program guidance clearly outlines the responsibility of its personnel to monitor veterans who receive program services; however, some medical facilities did not always follow this requirement. Until VHA enforces proper documentation of completed monitoring, it lacks assurance that program personnel are consistently monitoring and documenting changes in veterans' health conditions, potentially putting veterans' health and safety at risk.

The OIG also found weaknesses in VHA's billing process. While VHA paid about 80 percent of claims (26,900 of 33,600) in accordance with VDC claim authorizations, about 20 percent of the remaining processed claims (6,700 of 33,600) resulted in underpayments to provider agencies.[6] These errors occurred, in part, because VA did not provide adequate guidance to provider agencies regarding billing requirements and update provider agency names in the system. The team estimated that VHA underpaid provider agencies by at least $4.9 million from July 1, 2019, through June 30, 2020.

Finally, the OIG found a lack of guidance and oversight increased VHA's risk of misspending taxpayer dollars. Congress established the Program of Comprehensive

[5] Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error.

[6] For purposes of the audit, a claim is generally used to describe a group of claims for a veteran during a specific month. Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error.

Assistance for Family Caregivers (Family Caregiver Program) to assist caregivers of post-September 11, 2001, veterans and to improve their healthcare services. The VA MISSION Act of 2018 expanded the Family Caregiver Program to eligible veterans of all eras, and the expansion began on October 1, 2020.[7] The VDC and Family Caregiver Programs prohibit the authorization of similar personal care services, but VHA does not have a process to address payments for similar services. The audit team identified 42 veterans who received similar services from both programs during one or more months of FY 2020. The team used the estimated amount that VHA paid for the similar services provided to veterans enrolled in both programs to determine VHA's monetary risk. VHA could save at least an estimated $6.6 million annually by establishing controls to address unnecessary payments for personal care services provided by both the VDC and Family Caregiver Programs.[8]

Opportunities Exist to Improve VDC Program Policies and Budgeting

VHA relies on individual medical facilities to implement and operate local VDC programs, but some medical facilities are experiencing challenges implementing the program. In interviews with the audit team, facility personnel reported concerns about inadequate program guidance. Personnel at facilities without VDC programs also expressed similar concerns that contributed to not establishing the program. Although VDC program guidance discusses how to purchase care in the community and how to evaluate and monitor provider agencies, it does not address staffing; program roles and responsibilities at the national, network, and facility levels; or tracking workload and demand. In facilities without VDC programs, personnel referred veterans to other VHA programs, community adult day care, in-home respite care, or local non-VA community resources.

Another challenge facing medical facilities is the budget process for the VDC program, which involves several offices within VHA. The OIG determined that program funds are distributed differently across Veterans Integrated Service Networks and medical facilities, and VHA lacks an effective way to track program demand at the facility level for eligible veterans waiting for or interested in program services. Without current and complete program data, VHA does not have the necessary information to determine what resources are needed to support facilities. In addition, without this data, VHA leaders do not know the impact of the program on veterans and whether it is in VA's best interest to support further program expansion.

[7] The VA MISSION Act of 2018, Pub. L. No. 115-182, §§ 161-163 (2018).

[8] Appendix C provides details on the statistical sampling methodology, projections, and margins of error. Appendix D provides details on the audit's monetary benefits.

What the OIG Recommended

The OIG recommended the under secretary for health ensure program coordinators document their quarterly monitoring of the services veterans receive, improve the provider agency billing and payment process, and establish guidance to ensure veterans do not receive the same personal care services through the VDC program and the Family Caregiver Program. The OIG also recommended establishing procedures to assist in identifying program staffing needs, defining roles and responsibilities, and tracking demand for program services.

Management Comments and OIG Response

The acting under secretary for health concurred with recommendations 1–2 and 4–8 of the report and concurred in principle with recommendation 3. The acting under secretary's planned corrective actions are responsive to the recommendations and address the issues identified in the report. For recommendation 3, the acting under secretary agreed that errors occurred when provider information was not updated in VA's claims processing system, but noted the errors the audit team identified occurred only in the Fee Basis Claims System and not the Electronic Claims Adjudication Management System. The OIG points out that the audit team identified underpayments in both systems. VHA reported the Office of Community Care will work with the Office of Geriatrics and Extended Care as necessary to make sure that the Electronic Claims Adjudication Management System includes current provider agency information and expects this system update to be addressed by August 2021. This planned action meets the intent of the recommendation. The OIG will monitor VHA's progress on proposed actions until the intent of these recommendations is addressed and will then close them. Appendix E includes the full text of the management comments.

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Contents

Abbreviations

eCAMS	Electronic Claims Adjudication Management System
FY	fiscal year
GAO	Government Accountability Office
GEC	Office of Geriatrics and Extended Care
H/HHA	Homemaker and Home Health Aide
OCC	Office of Community Care
OIG	Office of Inspector General
VDC	Veteran-Directed Care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Older veterans may live alone, experience isolation, or cope with multiple health conditions. The Veterans Health Administration's (VHA) Office of Geriatrics and Extended Care (GEC) administers the Veteran-Directed Care (VDC) program to maximize veterans' functional independence and prevent or lessen the burden of disability on older, frail, and chronically ill patients, their families, and caregivers.[9] These programs provide a wide range of long-term services, including geriatric outpatient services, home and community-based long-term support, and end-of-life services.

The VDC program, one of VHA's 12 noninstitutional care programs, provides veterans with a budget to hire a caregiver and purchase the goods and services that will best meet their care needs and allow them to remain in their homes longer. According to VHA, the VDC program is ideal for veterans who live in remote and rural areas where homemaker and home health aide (H/HHA) services may be more difficult to obtain.[10] While medical facilities have the option to implement the VDC program, it is not available at all facilities.

The Office of Inspector General (OIG) conducted this audit to determine if VHA budgets and manages VDC resources to ensure veterans receive authorized home and community-based services and goods.

VDC Program Launch

Interested in increasing the number of veterans that could receive long-term services, VHA partnered with the Department of Health and Human Services and state agencies to provide program services. In June 2009, the Administration on Aging (part of the Department of Health and Human Services) published a grant announcement to states to develop or enhance community living programs. One of the goals of the grant program was to allow individuals at a high risk of nursing home placement to stay in their homes using home and community-based services. This grant included an option that allowed states to partner with VHA medical facilities to provide services to veterans under the veteran-directed home and community-based service program, or what is now the VDC program. State agencies interested in applying for this program were required to show interest from a local Veterans Integrated Service Network (VISN) or VHA medical facility, or approach local VHA personnel to determine their interest in developing a program. VHA also encouraged VISNs and facilities to contact state agencies if

[9] VA, "Geriatrics and Extended Care Program," accessed March 3, 2021, https://www.patientcare.va.gov/geriatrics.asp.

[10] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016. VHA pays for H/HHA services to help eligible frail or disabled veterans take care of themselves and manage their daily activities.

they were interested in developing a program. GEC was available to provide support, as needed. In addition, in FY 2009, VHA provided medical facilities funding to develop VDC programs.[11]

Growth in VHA Noninstitutional Care

VHA's noninstitutional care is provided in an outpatient or home setting. VHA defines this care as "encounters that occur within the community," VHA home-based health care, and home telehealth. VHA's budget for noninstitutional care services was about $3.3 billion in fiscal year (FY) 2020 and increased to about $3.5 billion for FY 2021.

In 2017, a demographics and utilization report conducted on behalf of GEC showed veterans reviewed in the VDC program used 37 percent fewer nursing home days of care after enrollment, whereas those enrolled in the H/HHA program used 55 percent more days of care. In addition, before program enrollment, the VDC group used almost twice as many nursing home days of care per user when compared to the H/HHA group. The changes in utilization before and after VDC program enrollment show that the program helps to keep veterans at risk of nursing home placement in their homes.[12]

Growth in VDC Program Participation

The VDC program provides veterans with a budget to hire a caregiver and purchase the goods and services to best meet their needs. Since FY 2017, the VDC program has grown significantly. The number of veterans in the program has increased by about 108 percent and expenditures have increased by about 97 percent. About a quarter of the veterans in the program in FY 2020 were 85 years old or older. The average annual cost per veteran in the program in FY 2020 was about $16,800. Table 1 shows the approximate number of veterans in the program by gender and the approximate amount spent for FY 2017 and FY 2020.

[11] VA, Acting Deputy Under Secretary for Health for Operations and Management Memorandum, "Community Living/Veteran-Directed Home and Community Based Service (VD-HCBS) Programs," August 10, 2009.

[12] The Lewin Group, Inc., *VD-HCBS & H/HHA Demographics and Utilization Report*, October 30, 2017.

Table 1. VDC Program Growth from FY 2017 through FY 2020

Description	FY 2017	FY 2020
Expenditures (in millions)	$37.3	$73.5
Number of participants	2,100	4,400
Male veterans	2,000	4,100
Female veterans	130	240

Source: VHA Support Service Center data as of September 2020 and March 2021.
Note: The increase in expenditures reflected in the table could be attributed to annual increases in veterans' personal budgets for VDC program services. Some numbers in the table were rounded for reporting purposes.

As of March 2021, VHA reported spending about $47.5 million on about 3,800 veterans in the VDC program in FY 2021.

VDC Program Administration

GEC is responsible for developing policy, monitoring program activity in home health care, and providing reports on compliance and performance.[13] VHA medical facility personnel identify veterans who are eligible for the program and refer them to a provider agency.[14] Provider agencies send bills to VHA's Office of Community Care (OCC) for reimbursement and reconciliation.

VHA Medical Facilities

At the time of a veteran's referral to the VDC program, the VHA medical facility determines a veteran's budget amount using VHA's Purchased Home and Community Based Services Case Mix and Budget Tool. The medical facility's program coordinator should include a veteran's program budget and any program assessment fees in the authorization for services. The program coordinator should also approve a veteran's spending plan, as well as any goods and services

[13] VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. GEC's program procedures do not specify this office's roles and responsibilities specific to the VDC program.

[14] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*. The audit team confirmed with VHA personnel that this document was dated December 23, 2010.

purchased as part of program participation.[15] According to guidance, medical facility personnel will monitor the status of veterans and their caregivers and their program service utilization on a quarterly basis by phone.[16] VHA guidance sometimes refers to a VHA medical facility, facility personnel, or a program coordinator. The guidance does not identify the position that is charged with carrying out program responsibilities on behalf of the facility. Furthermore, the guidance does not detail if the program coordinator should have clinical or administrative qualifications or maintain these responsibilities full-time or have them assigned as a collateral duty. At the facility level, the organization of the VDC program can vary. Most frequently, the program is administered in either the social work service line or the geriatrics, extended care, and rehabilitation service line.[17]

Provider Agencies

VHA medical facility personnel designate provider agencies for the program that assist enrolled veterans with developing spending plans.[18] Provider agencies are also responsible for educating and supporting veterans to act as employers and providing them with financial management services. In addition, provider agencies are responsible for billing VHA timely and accurately, as well as developing and submitting monthly detailed expense reports to the facility program coordinator.[19] Provider agencies are also expected to conduct face-to-face visits with the veterans at least quarterly to monitor well-being. The provider agency and medical facility may meet with veterans and their families to confirm services are being provided and the needs of both veterans and caregivers are being met.[20]

Provider agencies can include aging and disability resource centers, area agencies on aging, centers for independent living, or state units on aging that operate either as sole proprietors or

[15] VHA, National Non-VA Medical Care Program Office, *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*. The audit team confirmed with VHA personnel that this document was dated July 21, 2017. This guidance notes the program coordinator should receive a detailed report each month of a veteran's spending for the previous month from the provider agency. If the program coordinator sees a discrepancy between the spending plan and what was actually spent over the course of the month, the coordinator should direct the provider agency to review the case mix spending plan and, when appropriate, adjust it to reflect the veteran's care needs.

[16] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*.

[17] VHA, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, *2018 Geriatrics and Extended Care in VHA Survey Report*, June 2019.

[18] VHA guidance requires that provider agencies offering VDC services must meet program readiness criteria before they can begin enrolling veterans.

[19] *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*.

[20] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*.

hubs delivering program services. All provider types sign agreements with VA to administer program services, oversee the delivery of services, and provide financial management.[21]

Program Eligibility

All veterans interested in self-directed care and enrolled in VA's healthcare system are eligible to participate in the VDC program when "in need of nursing home care." Veterans are determined "in need of nursing home care" when one or more of the specified criteria are met.[22] Facility personnel use the criteria in table 2 to identify eligible veterans requesting care who are in need of program services as an alternative to nursing home placement.

Table 2. Criteria for Identifying Veterans Eligible for Program Services

Description of needs
Three or more activities of daily living dependencies, or
Significant cognitive impairment, or
Receiving hospice services, or
Two activities of daily living dependencies and two or more of the following: • Three or more instrumental activities of daily living dependencies, or • Recently discharged from a nursing facility or nursing home discharge contingent on receipt of home and community-based services, or • Recently discharged from inpatient rehabilitation facility or discharge contingent on receipt of home and community-based services, or • 75 years old or greater, or • Three hospitalizations or 12 outpatient clinic/emergency evaluations in past 12 months, or • Diagnosis of clinical depression, or • Lives alone in the community.

Source: Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures.

When a veteran does not strictly meet all the criteria set out in table 2, but nevertheless is determined by facility personnel to need program services, he or she may be enrolled in VDC. VDC services are intended for veterans whose home care needs exceed the average number of hours generally available through the H/HHA program at a medical facility. Others may have

[21] "Veteran Directed Care Program," accessed January 29, 2021, https://nwd.acl.gov/vdc.html.

[22] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures.*

had difficulty getting services through traditional provider agency-based home care systems.[23] However, there is no requirement that medical facilities document this when considering the veteran's eligibility for the VDC program.

Case Mix Tool

Medical facilities use VHA's Purchased Home and Community Based Services Case Mix and Budget Tool (case mix tool) to determine the appropriate funding based on a veteran's level of need for home services. The case mix tool rate is a dollar amount that includes a veteran's monthly spending budget and the provider agency's administrative fees.[24] These rates are updated yearly. Figure B.1 in appendix B further details the factors that inform a veteran's case mix tool results.

Veterans are assigned one of 12 case mix levels reflecting their clinical and functional needs. According to draft 2018 VHA guidance, when the case mix level is above a certain monetary threshold, facility personnel should evaluate the cost compared to the H/HHA program. Payments at each level vary by location.[25] Generally, the suggested range of service hours for the H/HHA program is from three to 16 hours per week. However, veterans requiring the highest level of care and at a high risk of nursing home placement may be eligible for up to 32 service hours per week.[26] Through the H/HHA program, facilities arrange for a homemaker or home health aide to provide personal care services to veterans in their homes.

Program Services and Supports

Provider agencies must assist participating veterans and their caregivers in arranging self-directed services based on their needs and preferences, even if the care is being provided by someone such as a family member.[27] Veterans in the VDC program hire and supervise employees, including family members and friends, to assist them with activities of daily living or instrumental activities of daily living.[28] Activities of daily living refer to the basic tasks of everyday life, while instrumental activities refer to a series of more complex tasks or functions

[23] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures;* VA OIG, *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*, Report No. 19-07316-262, November 23, 2020.

[24] *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*.

[25] VHA, GEC, *Veteran Directed Care (VDC) Program Procedures* (draft), October 1, 2018, revised November 2018.

[26] VA, Deputy Under Secretary for Health for Operations and Management Memorandum, "Case Mix Tool for Personal Care Services," August 28, 2017.

[27] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*.

[28] Lewin Group, *VD-HCBS Billing & Invoicing Procedures Guide: VD-HCBS Aging & Disability Network Providers*. The audit team confirmed with VHA personnel that this document was dated January 9, 2017. In addition, the team reviewed GEC's *Veteran Directed Care (VDC) Program Procedures* (draft).

that help maintain one's personal life and environment. Figure 1 includes examples of personal care services these employees provide to veterans.

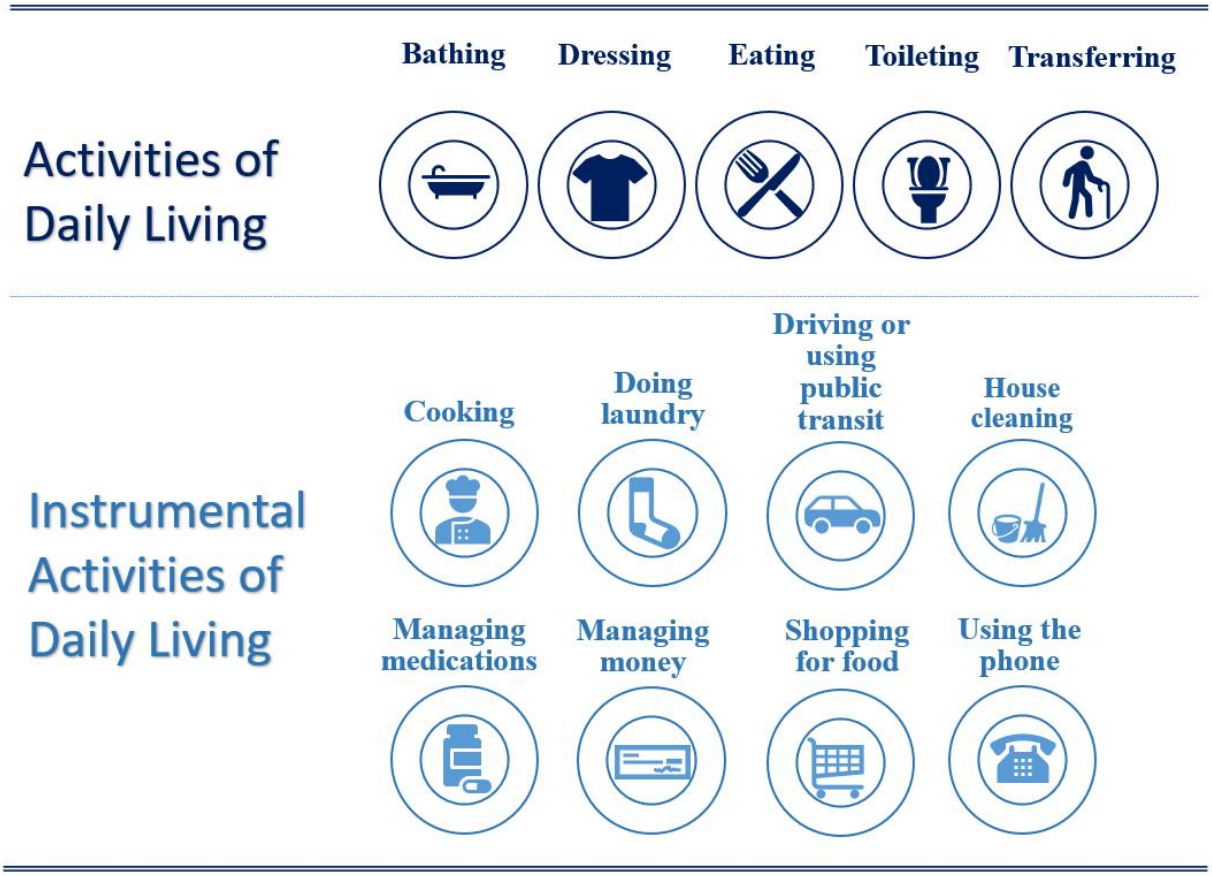

Figure 1. *Examples of activities of daily living and instrumental activities of daily living.*
Source: VA OIG analysis of VD-HCBS Billing & Invoicing Procedures Guide: VD-HCBS Aging & Disability Network Providers, and the National Caregiver Training Program, Caregiver Workbook, Module 4: Veteran Personal Care.

According to the 2010 program procedures, provider agencies must provide or assist in arranging self-directed services based on the needs and preferences of veterans or their caregivers participating in the VDC program. These agencies can also provide services such as

- adult day or respite care;
- assistive technology, such as an emergency response system;
- caregiver support, such as counseling; and
- goods and services needed to remain safely in the community.

Billing Process for Program Services

VHA medical facilities establish local procedures with provider agencies for when and how invoices will be submitted and the parties that will receive VDC invoices and subsequent monthly documentation. Provider agencies may submit program documentation to the program coordinator, the OCC point of contact who is responsible for processing invoices, or both.[29] Figure B.2 in appendix B provides an overview of the invoicing process for VDC services.

[29] Lewin Group, *VD-HCBS Billing & Invoicing Procedures Guide: VD-HCBS Aging & Disability Network Providers*.

Results and Recommendations

Finding 1: VHA Provided VDC Services to Veterans That Addressed Their Care Needs, but Program Management Needs Improvement

The OIG determined that VHA medical facilities generally provided VDC services that met veterans' care needs. However, the team identified weaknesses in program management that could cause VHA to potentially put veterans at risk, underpay provider agencies, and possibly misspend taxpayer dollars. Although VHA personnel appropriately matched the level of care to the spending plans for all randomly selected veterans reviewed, VHA did not establish guidance requiring program coordinators to document required quarterly monitoring. The team could not confirm that VHA personnel monitored an estimated 40 percent of veterans receiving VDC services (1,600 of 4,100), potentially putting veterans' health and safety at risk.[30]

The OIG determined that an estimated 20 percent of claims processed from July 1, 2019, through June 30, 2020, (6,700 of 33,600) resulted in underpayments to provider agencies. This occurred because VHA did not establish a control in the Electronic Claims Adjudication Management System (eCAMS) to prevent some inaccurate payments made to provider agencies. VA provided training on eCAMS requirements for provider agencies in 2019. However, billing procedures were not updated to inform agencies about these requirements. VHA underpaid provider agencies by at least an estimated $4.9 million from July 1, 2019, through June 30, 2020.[31]

Finally, the OIG found that some veterans received similar personal care services through both the VDC program and the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program). Both programs prohibit the authorization of similar personal care services, but VHA does not have a process to address payments being made for these similar services.[32] Specifically, VHA leaders do not know how many veterans are enrolled in both programs at the same time, or the extent to which programs are providing the same services to the same veterans.

[30] The estimated number of unique veterans (4,097) in the audit population is greater than the number of veterans in the sampling frame (3,928) because the sampling frame was incomplete at the time the sample was taken. Audit data were sampled at the end of May 2020, so no VDC services for June were available. In addition, data were missing from the databases for all of May and for part of several earlier months. The missing records are a result of lag time between (1) the date of service for a claim and (2) the date its status is resolved and the database is updated. Appendix C provides additional details on the statistical sampling methodology, projections, and margins of error.

[31] For purposes of this audit, a claim is generally used to describe a group of claims for a veteran during a specific month. To adjust the number of claims in the population, the average number of claims from September through November was calculated and applied to the months from December through June. This calculation resulted in an estimated number of claims of 35,564 (up from 23,632 in the sampling frame, a 46.3 percent increase). Because of the high margin of error for the total value of underpaid claims, at least an estimated $4.9 million represents the adjusted conservative estimate for these payments. Appendix C provides additional details on the statistical sampling methodology, projections, and margins of error.

[32] VHA Directive 1152(1), *Caregiver Support Program*, June 14, 2017, amended October 4, 2018; VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*.

As a result, VHA potentially paid an estimated $933,000 for similar personal care services provided to veterans 60 years old and younger who were enrolled in both the VDC and Family Caregiver Programs from October 2019 through September 2020. To be conservative, the team calculated this one-year estimate using the lesser of the two programs' monthly payment amounts per veteran.

Furthermore, the expansion of the Family Caregiver Program to include older veterans, which became effective as of October 1, 2020, increases the number of veterans eligible for both programs and the potential risk that VHA could potentially pay for the same services. The team applied the estimated amount that VHA paid for the similar services provided to veterans enrolled in both the VDC and Family Caregiver Programs who were 60 years old and younger (about $933,000) to estimate VHA's monetary risk of doing the same for dually enrolled veterans who are 61 years old and older. The team calculated the monetary risk for veterans 61 years old or older as about $5.6 million. By combining the totals for both age groups, the team estimated that VHA could save at least $6.6 million annually by not unnecessarily paying for services through both programs.[33]

What the OIG Did

The sampling frame for the audit review period included about 3,900 veterans who received VDC services from July 1, 2019, through April 30, 2020. The audit team analyzed a random sample of 68 unique veterans participating in the VDC program during this period to assess VHA's oversight of goods and services received by veterans and the detailed costs associated with that support. To complete this review, the team examined veterans' spending plans, electronic health records, and claims data. The team interviewed GEC and OCC officials and contacted VDC program officials from six VA medical facilities to learn how they enrolled veterans, established monthly budgets, and monitored veterans. The team also discussed the procedures used when addressing the enrollment of veterans in other VA programs that provide assistance with personal care services. Appendix A provides additional details on the audit scope and methodology.

The following sections discuss four factors associated with finding 1:

- veteran spending plans
- provider agency monitoring
- VHA monitoring

[33] The numbers used in these calculations were rounded for reporting purposes. Appendix C provides details on the statistical sampling methodology, projections, and margins of error. Appendix D provides details on the estimated monetary benefits.

- payments for similar personal care services

Spending Plans Matched Veterans' Authorized Care Needs

All 68 randomly selected veterans reviewed had spending plans that matched the level of care determined by VA. Provider agencies documented the spending plans, which were within the authorized budgets. VDC program guidance states that VHA medical facilities will set a veteran's budget rate based on the program's case mix tool. The VDC budget development uses an activities-of-daily-living–based case mix tool to screen for the appropriate funding based on a veteran's clinical and functional needs described by a case mix rate. This rate includes a veteran's monthly spending budget and the provider agency's administrative costs. Facility personnel input a veteran's state and county of residence, the case mix level, and dates for the authorization, and then the tool generates the monthly budget, administration fee, and annual authorization amount.[34]

The audit team reviewed veterans' care plans developed by VHA personnel and compared those care needs to the spending plans developed by the provider agencies. Example 1 shows how a veteran's care needs were within the case mix amount authorized by VA.

Example 1

A 68-year-old veteran with quadriplegia and a seizure disorder was authorized for VDC services for the period of October 2019 through September 2020 with a monthly maximum payment of approximately $4,700 (including the administrative fee of about $600). The veteran's monthly spending plan, which was developed by a provider agency, accounted for about 170 hours of care per month at a cost of about $3,600 in personal care services and a $540 administrative fee for a total of about $4,100 per month.

VDC program controls are in place and working to ensure veterans receive VDC services in accordance with their level of care needs.

Provider Agencies Monitored Veterans, but VHA Needs to Improve Oversight

While provider agencies monitored all veterans as required, the audit team could not confirm VDC program personnel monitored an estimated 40 percent of veterans receiving VDC services (1,600 of 4,100). Program guidance requires provider agencies to have oversight procedures to ensure that services are delivered to veterans on time and in a safe manner. At a minimum, program guidance requires a provider agency to conduct quarterly monitoring of veterans.

[34] *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*. Most commonly, authorized care refers to medical care that was approved and arranged by VHA to be completed in the community.

However, program guidance also requires that medical facility personnel monitor the status of veterans by telephone on a quarterly basis.[35] However, the team identified that VDC program personnel did not always meet this requirement.

The audit team identified that some provider agencies used standard templates to document quarterly monitoring that included checks on a veteran's health condition, hospitalizations, and satisfaction with program services. In contrast, facility program personnel explained they meet on a monthly basis to discuss veterans in their VDC programs, but do not always document those discussions in veterans' electronic health records. Because documentation is not mandatory, the team could not confirm in some cases whether program personnel were monitoring veterans in the program as required.

Multiple VHA noninstitutional care programs require quarterly monitoring of veterans receiving personal care services. According to GEC program personnel, the quarterly monitoring is intended to provide veterans with an opportunity to communicate changes in their care needs, issues with the provider agencies coordinating their care, and concerns with their caregivers' ability to provide personal care services. The OIG previously determined clinicians and program coordinators for the Family Caregiver Program did not adequately document in the electronic health records the extent to which veterans' health conditions changed.[36] Without proper documentation of completed monitoring, VHA lacks assurance that veterans in the VDC program are safe and receiving intended personal care services. VHA should consider assessing ways to improve required monitoring for veterans enrolled in similar programs designed to help them remain in their homes longer.

VHA Generally Paid Program Claims Accurately and in Accordance with Veterans' Budgets

The audit team's sample included cases from July 1, 2019, through April 30, 2020. The team reviewed program services data from claims processing systems, including the Fee Basis Claims System and eCAMS. In March 2019, VA implemented eCAMS with the intent to streamline, automate, and modernize the processing of community care claims received from provider agencies outside VA's community of care network.[37] The OIG found VHA paid about 80 percent of claims (26,900 of 33,600) in accordance with VDC claim authorizations. However, the remaining 20 percent (6,700 of 33,600) of processed claims resulted in underpayments to provider agencies. This occurred because provider agencies did not always include all required

[35] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures.*

[36] VA OIG, *Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed*, Report No. 17-04003-222, August 16, 2018.

[37] Community care is available to veterans when VA cannot provide the care needed. This care is provided by community providers on behalf of and paid for by VA.

information on program claims forms. In addition, eCAMS did not always apply the correct claims payment processing information. The team quantified the effect of any underpayments that resulted from these claim processing inconsistencies to show the potential impact to provider agencies. Underpayments were identified among claims processed in either eCAMS or the Fee Basis Claims System.[38] The team estimated that VHA potentially underpaid provider agencies by at least an estimated $4.9 million from July 1, 2019, through June 30, 2020.[39]

To determine if OCC paid VDC claims, the audit team matched the claimed amount to the paid amount to identify any discrepancies. The team provided the underpayment information to OCC personnel, who provided additional payment data and supporting documentation, such as denials and partial payment information. The team's error rate took the additional information into consideration.

VA System Lacked Updated Provider Agency Information: eCAMS did not always apply the accurate payment method when processing VDC claims. VDC claims are not subject to VA fee schedule rates due to the unique way provider agencies document VDC claims for processing.[40] Program guidance requires provider agencies to bill VDC claims on a per diem basis, by dividing the actual expenditures from a veteran's service plan for each month by the number of days in that month.[41] Therefore, the line item cost for VDC services is sometimes higher than the VA fee schedule allows. To address this issue, OCC developed procedures in eCAMS to identify the provider agencies as a "paid as claimed" vendor, rather than paying the claims based on VA's fee schedule rate. In the majority of cases, identifying the provider agencies as "paid as claimed" worked.

However, the team identified that the "paid as claimed" process did not work when the VDC provider list was not updated, causing eCAMS to apply the VA fee schedule rate to pay a VDC claim. OCC maintains the provider list, which requires manual updates when new provider agencies are approved to participate in the VDC program. As more medical facilities begin establishing VDC programs (as discussed in finding 2), it is imperative that OCC leaders establish a process to ensure the provider list is updated as needed and that eCAMS applies the list when processing VDC claims—not VA fee schedule rates. Doing so should improve the accuracy of OCC processed payments.

[38] The team did not compare the accuracy of claims processed by the Fee Basis Claims System and eCAMS during the audit.

[39] Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error.

[40] VA generally reimburses hospital care, medical services, and extended services at the applicable Medicare rate published by the Centers for Medicare and Medicaid Services. When this rate is not available, VA and third-party administrators reimburse at the lesser amount of (1) billed charges or (2) the VA fee schedule rate. The VA fee schedule rate is the amount published for the designated date of service time period.

[41] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures;* VHA, National Non-VA Medical Care Program Office, *Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide*.

VHA Did Not Update Procedures for Provider Agencies on Submitting Claims: VA provided training on eCAMS requirements for provider agencies in December 2019. However, billing procedures were not updated to inform provider agencies about these requirements, including the need to specify the authorization number on claims forms when submitting them for payment. OCC billing procedures for claims processed in eCAMS state that, to prevent claim denials, provider agencies must follow the claim submission guidelines by including the national provider identification number, the veteran's Social Security number, and the authorization/referral number on the claim.[42] However, the billing guidance for provider agencies did not reflect eCAMS requirements for proper claim submission and processing. Some provider agencies submitted claims that were missing this information, and OCC processors properly denied these claims. However, once denied, the provider agencies had to resubmit their claims for processing, which caused OCC processors to review them again before payment. To minimize incomplete claims and duplicate work, VHA should update program guidance for provider agencies on how to properly bill for VDC services. In April 2021, a director in GEC notified OCC that efforts were underway to update the program billing guidance.

VHA Does Not Have a Process to Address Payments for Similar Services

The VDC and Family Caregiver Programs both support veterans' needs for assistance with personal care services by paying veterans' family members to provide such services. The VDC program pays veterans, who then pay caregivers for personal care services, while the Family Caregiver Program pays veterans' caregivers directly. The VDC and Family Caregiver Programs prohibit the authorization of similar personal care services, but VHA does not have a process to address payments being made for these services.[43] Family Caregiver Program guidance restricts the authorization of a family caregiver if the services provided by the caregiver are simultaneously and regularly provided by or through another individual or entity.[44] VDC program guidance also states that home and community-based services provided through the program cannot duplicate any services that are already being provided.[45] This requirement is to

[42] VA Community Care, *Electronic Claims Adjudication Management System (ECAMS) Program Internal Controls Guidebook*, ver. 1.1, December 6, 2019.

[43] VHA offers resources, education, and support to veterans' caregivers through the Family Caregiver Program. Congress established the Family Caregiver Program to assist caregivers of post-September 11, 2001, veterans and to improve their healthcare services. The program provides training, counseling, mental health services, respite care, and a monthly stipend to a veteran's caregiver. Caregivers may also be eligible for health insurance benefits through VA's Civilian Health and Medical Program.

[44] VHA Directive 1152(1); VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*.

[45] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures.*

ensure that caregivers are authorized for veterans who do not routinely use other means to obtain personal care services.

The clinical eligibility criteria for both the VDC and Family Caregiver Programs are based on an assessment of a veteran's need for assistance with activities of daily living. When a veteran is deemed administratively eligible for either the VDC or Family Caregiver Programs, VHA providers assess the veteran's need for assistance with activities of daily living. The assessment results are the basis for determining the level of personal care services a veteran's caregiver provides to them daily.[46] For the VDC program, the assessment results determine the veteran's monthly budget. For the Family Caregiver Program, the assessment determines the monthly stipend amount of the veteran's caregiver. The OIG concluded that receiving services from both programs could be duplicative, as the activities of daily living assessment for both programs drives the amount of personal care services the veteran receives and the payment amount the caregiver receives. Table 3 compares the eligibility criteria for the VDC and Family Caregiver Programs.

Table 3. Eligibility Criteria for the VDC and Family Caregiver Programs

	VDC	Caregiver
Clinical eligibility criteria focus on needing assistance with activities of daily living	Yes	Yes
Care needs assessment includes mental health	Yes	Yes
Allows for the receipt of personal care services through other VA programs concurrently	No	No

Source: VA OIG analysis of Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures and VHA Directive 1152(1), Caregiver Support Program.

Initially, the audit team identified three veterans in the sample who were enrolled in both the VDC and Family Caregiver Programs at the same time. The team expanded its analysis to all veterans 60 years old and younger who received VDC services during FY 2020.[47] This match identified 42 veterans who received services from both programs during at least one month in FY 2020. The team then determined if VHA was paying for similar personal care services.

The audit team reviewed these veterans' eligibility assessments for both programs and identified the relationship between veterans and their caregivers. The team estimated that VHA paid for the same kinds of personal care services for these veterans. Using the lesser of the two programs'

[46] Family Caregiver Program guidance defines personal care services as the care or assistance provided by a caregiver that is necessary to support the veteran's health and well-being and perform personal functions required in everyday living that ensure the veteran remains safe from hazards or dangers incident to his or her daily environment. Personal care services include assistance with activities of daily living and providing supervision and protection based on symptoms or residuals of neurological or other impairment or injury for the veteran.

[47] The audit team used 60 years old and younger for the estimate because veterans in this age group have a higher probability of having served after September 11, 2001. This was used for estimating purposes only.

monthly payments per veteran, the team estimated that VHA potentially paid about $933,000 for similar personal care services between October 2019 and September 2020.[48] Examples 2 and 3 show the overlap of services that veterans received and the relationships to their caregivers.

Example 2

A 59-year-old veteran with a traumatic brain injury was approved for the Family Caregiver Program in January 2017 and received 40 hours of care per week. The Family Caregiver Program paid the veteran's sister a stipend of about $2,000 per month. In July 2019, the veteran was approved for VDC services. In August 2019, the veteran began receiving an about $1,600 monthly budget for VDC services. He used these funds to pay his sister to help with his personal care needs. The team determined that the veteran's sister was also the designated primary caregiver in the Family Caregiver Program. The OIG determined the veteran was receiving assistance through both programs for the same daily activities including bathing, feeding, and dressing. The veteran's electronic health record did not indicate the VDC program staff person was aware that the veteran was also enrolled in the Family Caregiver Program. VHA paid about $3,600 a month between both programs to support the veteran's personal care needs for a total of about $43,600 over approximately one year.

Example 3

A 36-year-old veteran with a traumatic brain injury was approved for the Family Caregiver Program in October 2011 with his caregiver (the veteran's mother) receiving a stipend of about $2,300 per month. Then, in February 2017, he was approved for VDC services. As of January 2020, the veteran's monthly budget was about $2,700 for VDC services, which he used to pay his mother to provide personal care services. The OIG determined the veteran was receiving assistance through both programs for the same daily activities including bathing, feeding, and dressing. The electronic health record indicated that the VDC program staff person was not aware that the veteran was also enrolled in the Family Caregiver Program until the audit team notified her in May 2020. This veteran and his caregiver received about $5,100 a month between both programs to support his personal care services for a total of about $183,000 over approximately three years.

[48] Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error. Appendix D provides details on the audit's monetary benefits.

VHA guidance does not establish how medical facility personnel should identify and address veterans who are receiving personal care services through both the VDC and Family Caregiver Programs. For example, the guidance does not specify that if payments are for similar services, then the veteran should receive either the higher or lower amount for those services. VHA leaders do not have an understanding of how many veterans are enrolled in both programs, nor the extent to which these programs are providing the same services to the same veterans.

To gain a better understanding of how VHA viewed situations involving veterans receiving the same services from both programs, the audit team interviewed personnel from GEC, VHA's Caregiver Support Program Office, and VDC program personnel.

- GEC program office personnel reported in June 2020 that they had not fully considered the impact of dual enrollment and had started having conversations with the Caregiver Support Program Office on how to handle these situations, especially with the expansion of the Family Caregiver Program.
- Caregiver Support Program personnel reported that it was their opinion that it is only a duplication of services when veterans who are enrolled in the VDC and Family Caregiver Programs are receiving similar services.
- VDC program personnel at the facility level reported that they were not aware of, and were not provided with, specific guidance that details how to manage dual enrollment. The lack of direction from GEC and the Caregiver Support Program Office was evident during interviews and the team's files reviews. For example, personnel at one facility identified during a quarterly monitoring check-in that a veteran was enrolled in both programs and took action to remove the veteran from the VDC program. However, the team also determined personnel at another facility were aware of a veteran's dual enrollment in the VDC and Family Caregiver Programs but did not consider the services duplicate. In this case, facility personnel reported that the personal care services were provided by different caregivers; therefore, they took no action to remove the veteran from the programs.

While VDC serves veterans from all eras, the Family Caregiver Program initially was limited to veterans with a serious injury incurred or aggravated in the line of duty on or after September 11, 2001. The VA MISSION Act of 2018 expanded the Family Caregiver Program to eligible veterans of all eras, as identified in table 4. This expansion started in phases and became effective as of October 1, 2020.[49]

[49] VA MISSION Act of 2018, Pub. L. No. 115-182, §§ 161-163 (2018).

Table 4. Family Caregiver Program Expansion

Date	Eligibility period
October 1, 2020	Veterans injured on or before May 7, 1975, can apply for the program.
October 1, 2022	Veterans injured after May 7, 1975, and before September 11, 2001, can apply for the program.

Source: VA MISSION Act of 2018.

The Family Caregiver Program was expanded to older veterans from conflicts including Vietnam and the Second World War. With the expansion of the Family Caregiver Program effective as of October 1, 2020, VHA is now at risk of paying this population of veterans and caregivers for the same personal care services. The audit team estimated that VHA could potentially pay an additional estimated $5.6 million annually if controls are not established to ensure veterans 61 years old or older and their caregivers are not paid for the same services through both programs.[50] As previously discussed, VHA may have paid an estimated $933,000 for similar personal care services provided to veterans 60 years old and younger from October 2019 through September 2020. Based on the sum of the team's estimates for both age groups, VHA could save at least an estimated $6.6 million ($933,371 + $5,637,024 = $6,570,395) annually by establishing guidance and controls for program personnel to address these unnecessary payments.[51]

Finding 1 Conclusion

The OIG found veterans' spending plans matched their care needs and VHA generally paid program claims according to veterans' budgets. However, eCAMS lacks a process to prevent some inaccurate payments being made to provider agencies. The team estimated that VHA underpaid provider agencies by at least an estimated $4.9 million from July 1, 2019, through June 30, 2020. In addition, although provider agencies monitored veterans, the team could not confirm that VHA program personnel consistently monitored and documented changes in veterans' health conditions, potentially putting veterans' health and safety at risk. As eligibility for the Family Caregiver Program continues to expand, VHA has an opportunity to save at least an estimated $6.6 million annually by establishing guidance to mitigate the risk of making unnecessary payments for personal care services to veterans also enrolled in the VDC program.

[50] The audit team estimated the $5.6 million by assuming that the average cost savings for veterans 60 years old and younger and 61 years old and older are similar. Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error.

[51] The numbers used in these calculations were rounded for reporting purposes. Appendix C provides details on the statistical sampling methodology, projections, and margins of error. Appendix D provides details on the audit's monetary benefits.

Recommendations 1–6

The OIG recommended the under secretary for health take the following actions:

1. Establish a process to ensure program personnel document veterans' quarterly monitoring in their electronic health records, such as by using a standardized template.
2. Establish a process to ensure the provider agency list in the Electronic Claims Adjudication Management System is updated as new provider agencies are added to the program.
3. Establish a process to ensure proper pricing in the Electronic Claims Adjudication Management System when paying program claims.
4. Update program guidance on claims submission and processing to make sure provider agencies are aware of the need to include all required information when submitting program claims.
5. Establish guidance to include processes that medical facilities must follow to determine if veterans are receiving the same personal care services through the Veteran-Directed Care program and the Program of Comprehensive Assistance for Family Caregivers, and how to address these situations, as appropriate.
6. Ensure program personnel determine if veterans enrolled in both the Veteran-Directed Care and the Program of Comprehensive Assistance for Family Caregivers are receiving the same personal care services and take action, as appropriate.

Management Comments

The acting under secretary for health concurred with recommendations 1–2 and 4–6 of the report and concurred in principle with recommendation 3. To address recommendation 1, the acting under secretary for health reported GEC will reaffirm the monitoring standard in its published program procedures and develop a standardized template for the electronic health record.

In addition, to address recommendation 2, GEC will establish an internal procedure as part of the new provider agency onboarding process to provide OCC's Payment Operations Management and the Financial Services Center with the necessary provider information to ensure timely payment of claims.

For recommendation 3, the acting under secretary for health noted recognizing the importance of paying claims accurately and noted the Fee Basis Claims System is no longer in use. Claims processors do not manually select a payment methodology in eCAMS; therefore, it is not necessary to establish a process to ensure claims processors apply proper pricing in this system. The accurate payment of VDC claims is dependent on the presence of a current and accurate

provider agency list in eCAMS. When eCAMS does not recognize a provider, the system automatically follows the payment methodology hierarchy, which can result in paying less than billed charges. GEC will collaborate with OCC to update provider agency information in eCAMS as necessary.

The Administration for Community Living updated billing guidance and provider agencies were trained in June 2021 to address recommendation 4.

To address recommendations 5, guidance was developed on avoiding potential duplication of services when VDC and the Family Caregiver Program are used concurrently. In addition, training for GEC and Family Caregiver Program staff was completed in April and May 2021. A memorandum is under development to ensure each facility is aware of these new requirements in addressing duplication of services.

To address recommendation 6, guidance will be developed on potential duplication of services when dual enrollment in VDC and the Family Caregiver Program occurs. This guidance will include review requirements at Family Caregiver Program enrollment, when there is a significant change in the veteran's condition, and annually. The guidance will also include specific actions to be taken when duplication of services is found.

OIG Response

The acting under secretary for health's planned corrective actions are responsive to recommendations 1–2 and recommendations 4–6. For recommendation 3, the acting under secretary noted that the underpayment errors occurred in the Fee Basis Claims System. However, the audit team identified underpayments that occurred in the Fee Basis Claims System and eCAMS. The acting under secretary's plans for OCC to work with GEC to provide updated provider agency information to be included in eCAMS should address these underpayments by August 2021. This planned action meets the intent of the recommendation. The OIG will monitor VHA's progress on its proposed actions until the intent of the recommendations is addressed. The OIG will then close these recommendations. Appendix E provides the full text of the management comments.

Finding 2: Opportunities Exist to Improve VDC Program Policies and Budgeting

VHA relies on individual medical facilities to implement and operate local VDC programs. Some medical facilities are experiencing challenges implementing the program. According to a 2018 GEC survey of medical facilities, challenges to administering the program included unclear program policy and a lack of facility leaders' support for the program.[52] The OIG found medical facilities without VDC programs also expressed similar concerns that contributed to some facilities choosing not to establish these programs. Although VHA program guidance discusses how to purchase care in the community and how to evaluate and monitor provider agencies, it does not address staffing; program roles and responsibilities at the national, network, and facility levels; or tracking workload and demand. In facilities without VDC programs, personnel referred veterans to other VHA noninstitutional care programs such as the H/HHA program.

The funding process for the VDC program involves several offices within VHA. The OIG determined that program funds are distributed differently across VISNs and medical facilities. However, VHA lacks an effective way to track program demand at the facility level for eligible veterans waiting for or interested in program services. GEC program personnel track veterans using expenditure data, rather than enrollment data, and do not have facility-level information on veterans waiting for VDC services. The VDC program benefits vulnerable veterans at risk of nursing home placement. Without current and complete program data, VHA does not have the necessary information to determine what resources are needed to support facilities. In addition, without this data, VHA leaders do not know the impact of the program on these vulnerable veterans and whether it is in VA's best interest to support further program expansion.

What the OIG Did

The audit team considered VHA program guidance, research studies, survey reporting, and budgeting practices and procedures to determine how medical facilities manage and fund the program. The team contacted 18 VHA medical facilities without VDC programs and followed up as necessary. Using responses to these questions, the team determined when there was an interest for the program at these facilities and what actions were taken when veterans requested VDC program services. The team interviewed VHA personnel at medical facilities with and without VDC programs about any challenges associated with the program, and interviewed officials and personnel in GEC, VHA's Office of the Chief Finance Officer, the Allocation Resource Center, and the Office of Enrollment and Forecasting about VHA's community care budget. In addition, the team contacted VISN chief financial officers and budget personnel involved with medical facilities' VDC budgets and interviewed medical facility personnel responsible for managing the

[52] VHA, *2018 Geriatrics and Extended Care in VHA Survey Report*.

VDC program about their involvement with local program budgets. Appendix A provides additional details on the audit scope and methodology.

The following sections discuss six factors associated with finding 2, including

- challenges reported by medical facilities with VDC programs,
- challenges reported by medical facilities without VDC programs,
- referral of veterans to other programs and services,
- lack of adequate guidance on program management,
- distribution of program funds, and
- tracking of facility demand.

Challenges with Operating the VDC Program

VHA relies on individual medical facilities to implement and operate local VDC programs. The Office of Management and Budget Circular A-123 requires management to establish and maintain internal controls necessary to achieve the objectives of effective and efficient program operations.[53] According to a 2017 VA research study, the VDC program was expected to expand to about 90 medical facilities during the next three years of the program's operation. However, according to the study, VDC program expansion did not progress at the planned pace due to changes in VA leadership and budget.[54] In a 2018 GEC survey of medical facilities, VHA reported challenges to administering the program that included unclear program policy and a lack of facility leaders' support for the program. GEC received 117 responses about why the VDC program did not exist at facilities. According to this survey, the top three responses to this question were a lack of

- budget/funding (43),
- staff (36), and
- local expertise (25).[55]

[53] Office of Management and Budget, Circular A-123, "Management's Responsibility for Enterprise Risk Management and Internal Control," July 15, 2016.

[54] "Evaluation of Veteran Directed Home and Community Based Services," VA Health Services Research & Development, accessed January 28, 2021, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141704558.

[55] VHA, *2018 Geriatrics and Extended Care in VHA Survey Report*.

The audit team's interviews with one VISN and six medical facilities with the VDC program identified challenges with operating the program.[56] For example, a VISN 10 official involved with the program reported there was no clear guidance and support for the program. VDC personnel at the White River Junction VA Medical Center in Vermont reported there is no local policy detailing the processes of the program. They used the 2018 draft program guidance to implement the program. VDC personnel from the Montana VA Health Care System in Fort Harrison, Montana, reported to the audit team that one of the challenges they faced was the lack of staff to support the administration of the program.

Figure 2 identifies the 69 medical facilities with operational VDC programs and facilities starting the program as of September 2020.

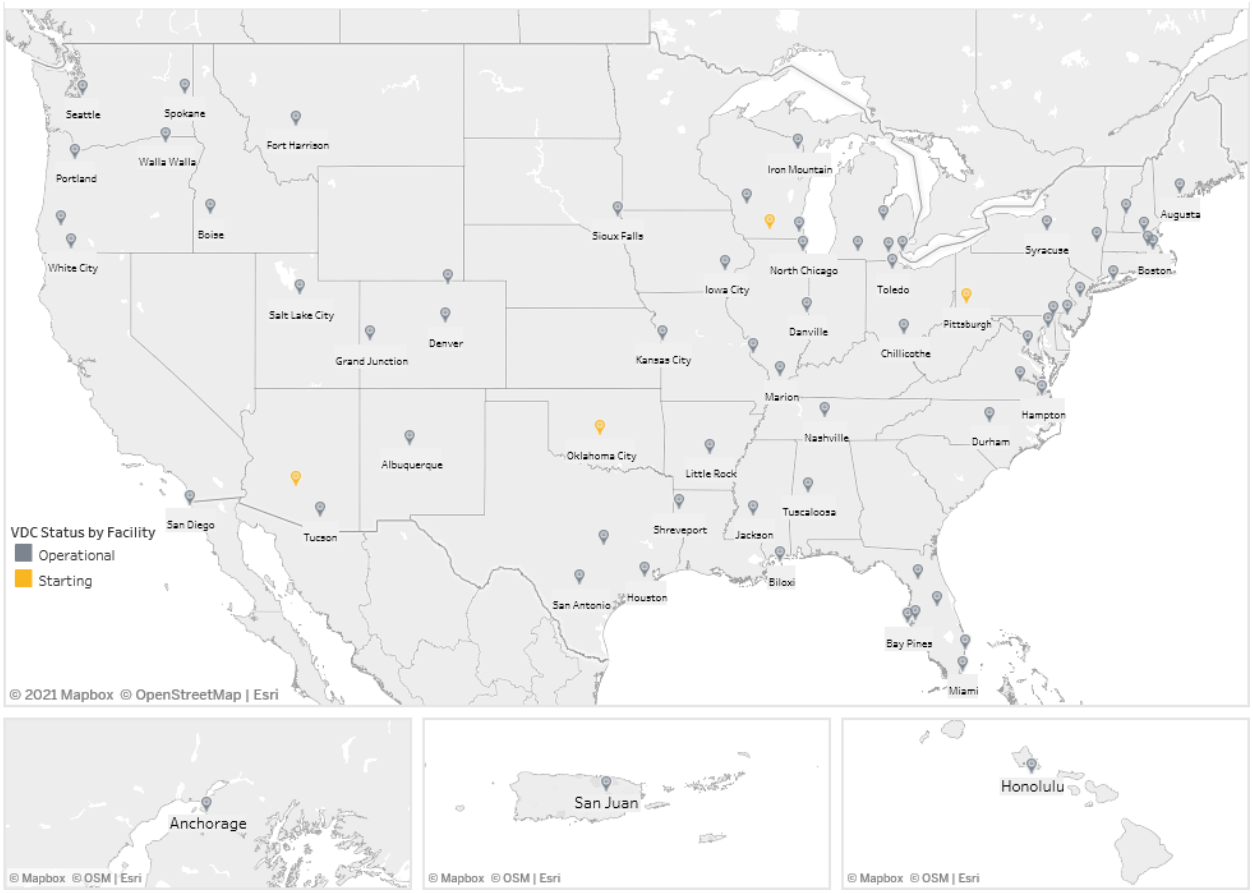

Figure 2. *Locations of VHA medical facilities with an existing VDC program or establishing the program. Source: VA OIG analysis of GEC's Veteran Directed Home and Community Based Services Program VDC Program List provided in September 2020.*

[56] The audit team contacted six VISNs and eight medical facilities about the program during the audit. Appendix A provides additional details on the audit scope and methodology.

Concerns with Funding and Staffing Limit VDC Program Expansion

VHA medical facilities without the VDC program also had similar concerns that contributed to some facilities choosing not to establish the program. As of September 2020, 76 facilities did not have VDC programs. Figure 3 shows the 76 facilities without VDC programs, including facilities that had programs no longer in operation and facilities that expressed interest in the program to GEC but had not taken steps to establish the program.

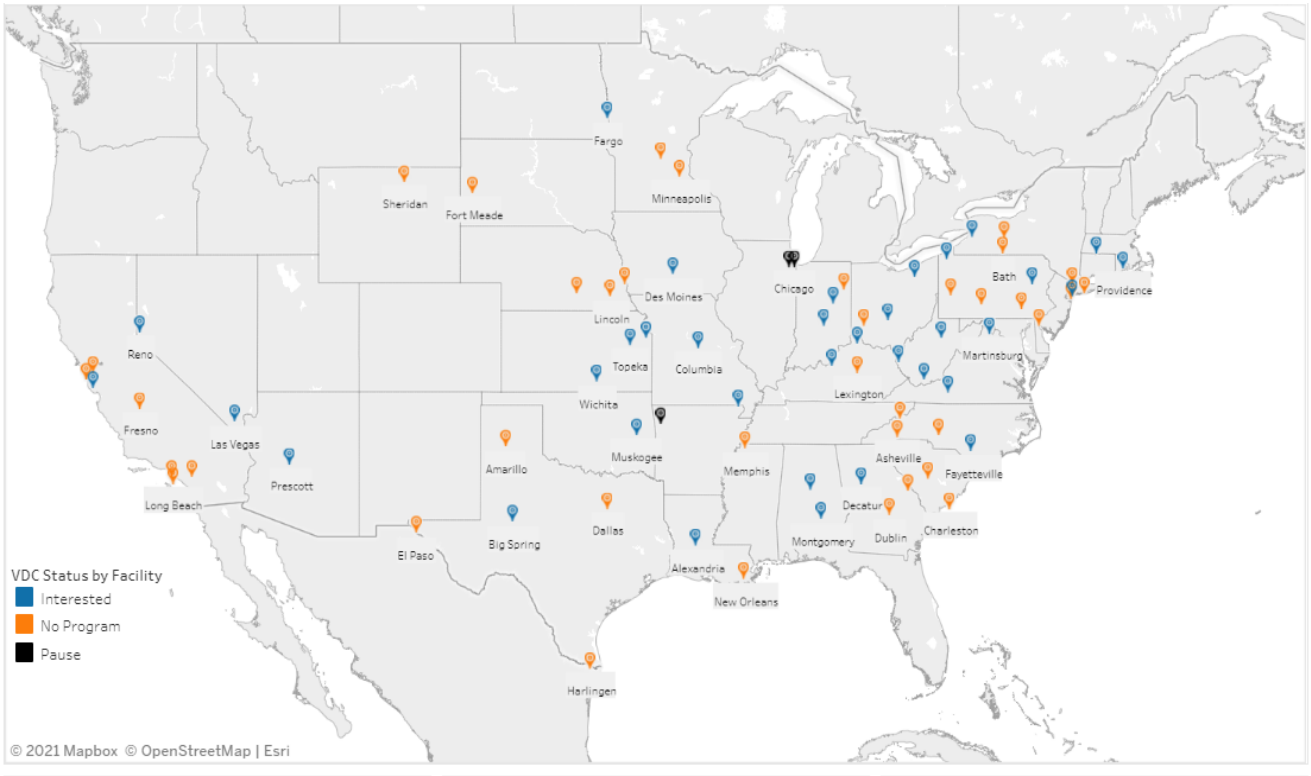

***Figure 3**: Locations of VHA medical facilities without a VDC program.*
Source: VA OIG analysis of GEC's Veteran Directed Home and Community Based Services Program VDC Program List provided in September 2020.
Note: This map includes facilities without VDC programs and facilities that had programs that are no longer in operation (or are paused). There are two facilities in Chicago, Illinois, with programs that are paused. In addition, there are two facilities in New York City, New York—one is interested in the program and one has no program.

According to GEC program office personnel, medical facilities do not need GEC's approval to establish the program. In addition, there is no requirement for each VA medical center to have a VDC program. GEC's only requirement for VDC is that VHA approve provider agencies through the readiness review process.[57] GEC program office personnel told the audit team they

[57] VHA, *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures.*

spoke to 35 facilities that expressed interest in the program; however, facilities got discouraged when they learned of the staffing needs for administering the program locally. According to GEC personnel, there has been reluctance from facility leaders to have designated program staff and there is no advance funding available for staffing. GEC personnel told the team that facility staff already have heavy workloads, and the lack of available staff is the main issue for not starting or expanding the program. In March 2021—after the team started its review—the assistant under secretary for health for patient care services/chief nursing officer issued guidance to VISN directors on the management of demand for noninstitutional care services following the retirement of VA's electronic wait list.[58] However the team was unable to assess the impact of this new guidance to VHA medical facilities.

Three of the 76 facilities had VDC programs that are no longer in operation (or are paused) because provider agencies no longer provide program services. GEC program office personnel did not have information on when exactly provider agencies withdrew from the program. However, they reported the provider agencies withdrew due to restrictive spending plans and VA's late payments. Program office personnel told the audit team there is a demand for VDC services at the three facilities, but as of December 2020, they had not yet been able to find replacement provider agencies.

Medical Facilities Reported Different Reasons for Not Implementing the VDC Program

The audit team randomly selected and contacted 18 facilities that did not have local VDC programs as of May 2020 to learn more about these facilities' interest in establishing a program and factors that affect their ability to do so. The team also asked personnel from these facilities what they do when veterans request VDC program services. VHA personnel at 15 of 18 facilities without VDC programs reported that veterans are referred to the H/HHA program, community adult day care, in-home respite, or local non-VA community resources.[59] These programs offer veterans a variety of services that can help them live independently at home.

[58] VA, Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer Memorandum, "Guidance Memorandum: Management of demand for non-institutional care (NIC) services following retirement of the Electronic Wait List. Non-institutional care includes services such as Home-Based Primary Care (HBPC) and Purchased Long Term Services and Supports (PLTSS)," March 31, 2021.

[59] VA OIG, *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*. The OIG reported VHA cannot be certain that veterans received intended H/HHA program services. The OIG identified 22 facilities using additional requirements not specified in VHA guidance that may unintentionally have resulted in inconsistent access to services for some veterans across facilities. In addition, the OIG could not conclusively identify the total number of medical facilities where veterans were waiting on an electronic waiting list specifically for H/HHA services. Appendix B provides additional details about prior related reports and the status of recommendations.

Table 5 details the reasons VHA personnel reported to the audit team for why these facilities are not providing VDC services.

Table 5. Reasons Facilities Did Not Establish a VDC Program

Reason	Number of facilities
Availability of other VA programs and state resources that adequately met veterans' needs	7
Financial limitations for program budget	3
Lack of dedicated full-time equivalents (employees) focused on program implementation and oversight	3
Lack of formal and standardized national policies and procedures for how to implement and manage the program	2
No demand for the program	3
Local leaders not supportive	1

Source: VA OIG analysis of responses from personnel at 18 medical facilities without the VDC program.
Note: Some personnel reported multiple reasons.

Personnel at 10 of the 18 facilities reported they had received one or more requests for the program within the last 12 months. The audit team contacted two of these facilities to determine why they had not established a VDC program. These facilities reported concerns with the lack of formal guidance on how to establish a program. The William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin, started preparing to implement the program in February 2019 and was still establishing it in November 2020. The purchased community care program coordinator at this medical facility contacted another facility that was already operating the program to determine the process and program needs. According to the coordinator, there was no standardized guidance that laid out all that is needed to establish the program. Similar concerns were voiced by personnel at the other medical facility contacted by the team. GEC should consider establishing procedures that facility personnel can use to make an informed decision about initiating the program locally.

VDC Guidance Does Not Provide Adequate Information on Program Management

The VDC program lacks definitive program guidance for medical facilities to follow when operating the program. The Office of Management and Budget Circular A-123 notes management is responsible for establishing control activities, such as policies and procedures, and monitoring program operations.[60] The audit team confirmed GEC's VDC program

[60] Office of Management and Budget, Circular A-123.

procedures were issued in December 2010 and subsequently updated in draft format in July 2013 and October 2018. However, according to GEC, these guidance documents were considered to include best practices rather than actual procedures. GEC also verified to the team that OCC's program procedures were issued in June 2015 and again in July 2017. The team reviewed GEC's December 2010 guidance and OCC's July 2017 guidance to determine if they contained enough information on program elements relevant to medical facilities operating the program. Table 6 summarizes the results of this review.

Table 6. Review of Program Elements in Final GEC and OCC VDC Program Guidance

Program elements defined	GEC*	OCC
Roles and responsibilities for the program to include GEC, VISN, and medical facility leaders	No	No
Staffing needed to establish and manage the program	No	No
Tracking workload and demand for program services	No	No
Purchase of program services from provider agencies	Yes	Yes
Billing and payment procedures for provider agencies	Yes	Yes
Program workload reporting	Yes	No

Source: VA OIG analysis of final VDC guidance confirmed as issued in 2010 and 2017.
**VHA, Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures, with a confirmed date of issuance of December 23, 2010.*
VHA, National Non-VA Medical Care Program Office, Veteran Directed-Home and Community Based Services (VD-HCBS) Procedure Guide, with a confirmed date of July 21, 2017.

The OIG found that VHA has taken steps to update and clarify guidance. GEC's 2018 draft program guidance provided more detailed instructions regarding the roles and responsibilities for VA facility staff.[61] This draft guidance provided additional guidance on the responsibility for medical facilities to monitor veterans' status after hospitalization, addressed how to record program workload, and included a detailed listing of goods and services not allowed by the VDC program. However, the 2018 guidance did not fully address all the elements listed in table 6, such as the roles and responsibilities for the program. In December 2020, GEC reported that it hoped to update VDC program guidance to include it in OCC's Field Guidebook in either late spring or early summer 2021.[62] Until VHA provides program guidance that addresses all program elements, it cannot ensure the program is being effectively administered.

[61] VHA, GEC, *Veteran Directed Care (VDC) Program Procedures* (draft).

[62] The guidebook defines systematic business and clinical processes for facility community care staff as they coordinate veteran care with community partners.

Distribution of VDC Program Funds Varied across Networks and Facilities

The budget process for the VDC program involves several offices within VHA. VHA's Office of the Chief Finance Officer is responsible for budget development and allocation, monitors the execution of funds to VISNs, and oversees financial management and accounting operations. The community care budget, which includes funds for VDC services, is developed using the VA Enrollee Health Care Projection Model as a baseline.[63] VHA's Office of Enrollment and Forecasting has the lead responsibility for developing the projections from this model and annually updating the assumptions that affect those projections. OCC, along with VISNs and medical facilities, manage the distribution of VDC funding as part of the community care budget. VDC does not have a dedicated budget, and funding for the program is included as part of the H/HHA budget. GEC reported there are a few smaller home and community-based services programs that do not have their own line items in the President's budget submission. These programs include the Program of All-Inclusive Care for the Elderly, the Medical Foster Home program, and the Bowel and Bladder program.

The OIG determined that GEC works with the Office of Enrollment and Forecasting to ensure that appropriate resources are available for the VDC program. According to GEC personnel, they meet with the Office of Enrollment and Forecasting throughout the fiscal year, including to discuss the annual budget. GEC personnel also reported that when they discuss community care programs, the VDC program may be discussed. However, the team could not confirm the extent to which GEC personnel discuss the VDC program as minutes are not taken at these meetings. Figure 4 illustrates the budgeting process for community care services, including the VHA components involved with it.

[63] This projection model is an actuarial model that projects future medical care costs by applying health care trends and demographic projections to base-year obligations and utilization actuals.

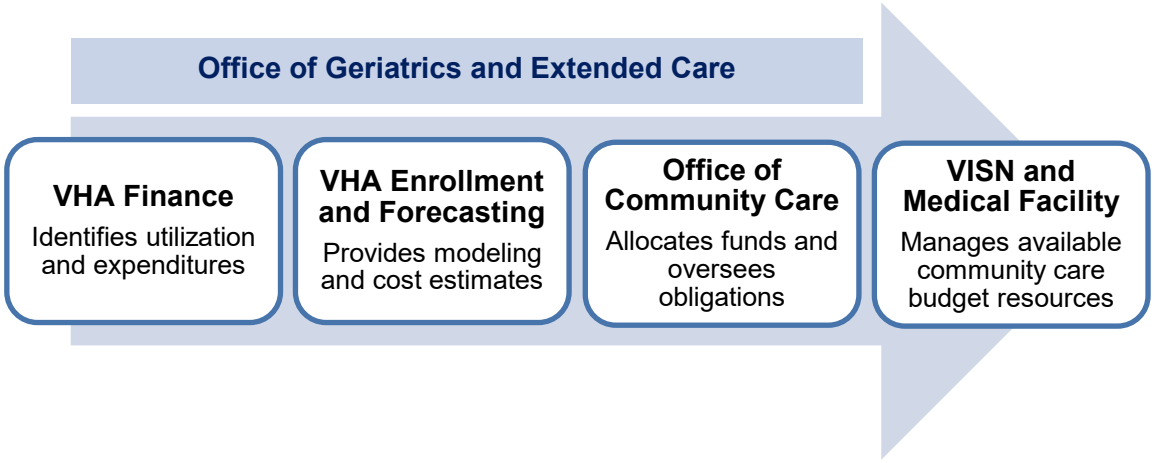

Figure 4. *VHA's community care budget process.*
Source: VA OIG analysis of VA budget and organizational documents and interviews.
Note: GEC provides input on noninstitutional care programs, such as the VDC program, during this process.

VISNs and medical facilities are responsible for managing their available budgetary resources for community care programs. VHA guidance also allows VISNs to move budget funding between facilities within their respective networks.[64] The six VISNs and medical facilities contacted by the audit team allocate funds differently based on how many local facilities offer VDC services. The involvement of financial personnel in funding the VDC program varied among these VISNs and facilities. In addition, VA medical facility program personnel reported not being involved with the distribution of VDC funding, which is generally managed by facility OCC personnel. The following are two examples:

- The VISN 6 chief financial officer reported working with medical facilities on program budgets and funding. In contrast, at VISN 10, the chief financial officer reported VISN personnel do not help develop the VDC budget; they only monitor how funds are spent.
- The chief financial officer at the White River Junction VA Medical Center reported no involvement with the budget submission or management of the facility's VDC funds. This official reported OCC was responsible for the program budget at the facility. However, program personnel at the Milwaukee VA Medical Center in Wisconsin who were familiar with program funding reported they had some involvement with the funding for the VDC program.

The OIG concluded VHA lacks assurance that the allocation of VDC resources is in alignment with facilities' needs when VISN and facility personnel are not providing their input on the distribution of funds for the program.

[64] VHA, *VHA 2020 Overview—Medical Community Care Fiscal Guidance*, obtained on September 24, 2020.

VHA Does Not Track Facility Demand for VDC Services

In its annual budget submission, VA estimates resources needed for the VDC program in the same line item as the H/HHA program. The demand for VDC is captured by the demand for H/HHA services within the Enrollee Health Care Projection Model. According to GEC personnel, other VHA Support Service Center reports are used to track veteran program referrals. However, these reports only identify a unique count of veterans who have at least one referral. In addition, GEC personnel reported using data from two noninstitutional care reports from the VHA Support Service Center to track veterans' use of VDC services. While these two reports identify unique veterans in the program by VISN and medical facility, they are based on program payment data and do not show actual veteran enrollment in the VDC program. It is possible that some veterans who are enrolled in the program may not be counted in these reports. For example, due to a short hospitalization, institutionalization, or a temporary loss of a provider agency, a veteran might not be able to access VDC services. In addition, these reports do not account for the unmet demand of veterans who receive care at the 76 medical facilities identified during the audit without the VDC program.

In the past, VHA used electronic waiting lists to track demand for different GEC program services. In 2014, VHA issued a memorandum requiring the use of electronic waiting lists any time home health services, including VDC services, could not be arranged immediately. However, this guidance specified that medical facilities use the same numeric code to track veterans waiting for VDC program services and services available through other noninstitutional care programs.[65] Thus, VHA was unable to use this information to determine how many veterans were waiting specifically for VDC services. Furthermore, GEC program office personnel reported there was only limited VDC-specific information in electronic waiting lists. They also stated VHA medical facilities may have had their own processes to track demand for the VDC program.

In June 2020, the assistant under secretary for health for operations announced a plan to use consults instead of electronic waiting lists to identify patients who could not be scheduled for an appointment or who chose to wait for a VHA provider instead of a community provider. Effective December 1, 2020, the electronic waiting list will no longer be used to track patients who cannot be scheduled for an appointment.[66] According to GEC electronic wait list field training, which was reportedly updated in March 2021 and provides guidance to medical facilities on all purchased long-term care services, consults for these services may remain active until services are available, for 180 days, or until the veteran no longer needs care. It is unclear if

[65] VA, Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services," July 22, 2014.

[66] VA, Assistant Under Secretary for Health for Operations Memorandum, "Simplification of New Patient Scheduling and Elimination of VHA Electronic Wait List," June 18, 2020.

these new practices will improve VHA's information on veterans' unmet needs for program services.

Finding 2 Conclusion

Due to local facility discretion regarding the VDC program, some veterans who would be eligible for program services may instead receive services through other programs. Medical facilities with the program reported challenges with staffing, budgets, and unclear guidance. Some medical facilities without the program reported similar concerns that contributed to choosing not to establish the program. Budgetary concerns and the lack of clear guidance may also hinder facilities' ability to provide these services. Until steps are taken to address these challenges and ensure appropriate program guidance and support, VHA is not positioned to know if expanding or reducing VDC program services would benefit all veterans.

Recommendations 7–8

The OIG recommended the under secretary for health take the following actions:

7. Establish procedures to identify program staffing needs and define program personnel's roles and responsibilities at the national, network, and local levels.
8. Update procedures for tracking and reporting demand for and use of program services and use these data to inform yearly cost estimates for the program.

Management Comments

The acting under secretary for health concurred with recommendations 7 and 8.

According to VHA, GEC is working with OCC on a staffing model for all purchased long-term services and supports programs, including VDC, to address recommendation 7. Roles and responsibilities for each level—national, VISN, and facilities—will be included in a procedures document.

To address recommendation 8, GEC will also develop a broad review and an internal procedure to estimate demand for VDC and use this information, including scheduling data, for budget development.

OIG Response

The acting under secretary for health's comments and corrective action plan meet the intent of the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when VHA provides evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the full text of the management comments.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from May 2020 through May 2021. The team's review of veteran participants focused on whether VHA budgeted and managed VDC program resources to ensure veterans received authorized home and community-based services and goods. The sampling frame for the audit review period included about 3,900 veterans receiving program services from July 1, 2019, through April 30, 2020.

Methodology

The audit team interviewed officials and personnel in VHA's GEC and OCC involved with overseeing the program, and contacted chief financial officers and personnel involved with the VDC program at six judgmentally selected VISNs. The team also interviewed facility personnel familiar with program services at eight judgmentally selected VHA medical facilities.

To gain an understanding of the VDC program, the team reviewed VHA's budget submissions, GEC's Transformation Operational Plan, and guidance on program procedures. The team also reviewed prior audit work on VA's budget process and programs providing personal care services to veterans, including OIG reports on VHA's H/HHA program and the Family Caregiver Program.[67]

Review of Program Research Studies

From January 2020 through August 2020, the audit team collected and reviewed 10 research studies to identify challenges VHA medical facilities faced in providing geriatric and extended-care services to older veterans. The team also reviewed these studies to gain a better understanding of the utilization of the VDC program compared to other VHA purchased-care programs.

Communication with Medical Facilities without a Program

To better understand the challenges or other concerns regarding VDC program implementation and determine whether veterans served by VHA medical facilities could participate in the program at other facilities, the team contacted 18 of 70 facilities that did not operate a VDC program as of June 2020. Working with an OIG statistician, the audit team randomly selected these 18 facilities by stratifying them into three groups (low, medium, and high) based on their

[67] VA OIG, *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*; VA OIG, *Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement*, Report No. 18-04924-112, July 25, 2019; and VA OIG, *Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed*.

veteran populations and then selecting six facilities per group. In July 2020, the team worked with the statistician to develop five standardized questions with follow-up questions based on responses. The questions related to demand for the VDC program at these facilities and what actions were taken when veterans requested VDC program services. The team contacted the H/HHA program coordinators from these facilities via email and asked them, or someone else familiar with the VDC program, to answer the questions. The team received responses from all 18 facilities and confirmed that none of them had a VDC program. The team also followed up with program personnel to further clarify their responses.

Program Participant Review

The audit team developed an electronic data collection instrument to review a random sample of 68 veterans in the VDC program from July 2019 through April 2020 at 28 VHA medical facilities. The instrument captured the elements required by program guidance. The team used this instrument to consistently review claims data on program services from the Fee Basis Claims System, eCAMS, and the Community Care Non-Network Care System. The team also used the instrument to review veterans' electronic health records in VA's Computerized Patient Record System. In addition, the team used this instrument to identify potential deficiencies in the following areas: (1) program authorization information (authorization period, monthly budget, administrative fee, and case mix results); (2) claim payment information (amount claimed versus amount paid and total spent on an authorization versus the total authorized budget); (3) provider agency verification; and (4) monitoring by medical facilities and provider agencies.

The audit team evaluated whether veterans received authorized goods and services from provider agencies and whether VHA accurately processed claims. In addition, field personnel provided additional documentation for the veterans in the sample, which the team considered during its reviews. The team also matched information on participants in the VDC program to information on participants in the Family Caregiver Program to identify veterans in both programs.

Internal Controls

The audit team assessed the internal controls for VHA's VDC program that were considered significant to the audit objective. The team reviewed the five internal control components—control environment, risk assessment, control activities, information and communication, and monitoring—and the associated principles for each component and determined all five components of internal controls were significant to the audit objective. The team assessed the design, implementation, and operating effectiveness of these internal controls as necessary to address the audit objective and identified several deficiencies as outlined below.

- Control environment: VDC program guidance did not detail specific roles and responsibilities for VA medical facility program personnel, which hindered some VA medical facilities from providing VDC services to veterans.

- Risk assessment: The OIG determined that some VHA medical facilities enrolled veterans in the VDC and Family Caregiver Programs at the same time, creating the potential risk that VA paid twice for the same personnel care services provided to veterans.
- Control activities: While VDC program guidance clearly outlines the control activities to monitor veterans who receive program services, the OIG determined that some medical facilities did not always follow these requirements. This increased the risk that veterans were not receiving intended services from provider agencies and their caregivers.
- Information and communication: The OIG determined that VHA lacked accurate national data on program demand to use when allocating resources at the medical facility level for eligible veterans waiting for or interested in program services. Therefore, VHA was neither fully aware of the number of veterans using VDC program services nor effectively managing resources to enable veterans to stay in their homes longer.
- Monitoring: The OIG determined that VHA was not providing programmatic oversight monitoring responsibilities at the national level. This included the following key areas: (1) monitoring demand for VDC services at VA medical facilities without a VDC program, and (2) monitoring VA medical facility personnel's completion of quarterly monitoring of veterans. The team also determined that program personnel at the facility level did not always follow monitoring requirements, as addressed under control activities above.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators within its documentation reviews, interviews, and contacts with medical facility personnel. The team identified some instances of potential fraud during this audit and referred these matters to the OIG's Office of Investigations.

Data Reliability

The audit team assessed the reliability of program data for VDC services that VHA provided from July 2019 through April 2020. In addition, the OIG determined if program data were sufficient for selecting a random sample of veterans. The team also assessed the reliability of claims payment data to determine if the data were sufficient for calculating payments that VHA made to provider agencies providing services to veterans during this period.

The audit team tested program data using both information provided by personnel and documentary evidence provided by VHA.

In addition, the team

- discussed relevant sources of computer-processed data with VHA officials,
- considered VDC program guidance that identified Healthcare Common Procedure Coding System codes T1020 (a per diem rate for all monthly program expenses) and T2024 (a one-time assessment program fee to cover a provider agency's costs to enroll a veteran) to select program data,
- considered the use of Purpose of Visit Code 27 to identify relevant claims,[68]
- compared veteran payment information (Fee Basis Claims System and eCAMS) between appropriate information systems to identify any incorrect or incomplete information, and
- conducted basic data reliability checks on information systems data to identify any incomplete or missing data fields.

Furthermore, the audit team verified the reliability and accuracy of the data by requesting documentation from VHA facility personnel for each of the items reviewed in the audit sample. The team compared veteran payment information between multiple information system data sources and VHA documentation. The team also discussed the reliability of payment data captured in program claims with responsible personnel.

The audit team also matched information on veterans in the VDC and Family Caregiver Programs to identify veterans enrolled in both programs. The team used veterans' enrollment dates to identify any overlap in program services. From the sample of 68 veterans, the team identified three veterans who were in both programs simultaneously. Because of these matches, the team expanded the review to all veterans 60 years old or younger in the VDC program during the audit review period. Then, the team compared these veterans to participants in the Family Caregiver Program.

Based on this reliability assessment, the OIG concluded that the data used were appropriate and sufficient for purposes of the audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain

[68] According to VHA's *Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures*, the VDC program is enrollment-based. During the audit, program claims were recorded in the Fee Payment System using Purpose of Visit Code 27. An entry is made for each day the veteran is enrolled in the program, regardless of whether a service is rendered on each day, to account for the cost of goods, provider agency service coordination and administration, and financial management services. The invoiced amount, once certified, is divided by the number of days in the month. That daily rate with this code is entered into the Fee Payment System. Healthcare Common Procedure Coding System codes are T1020 and T2024.

sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Background

Case Mix Tool

At the time of a veteran's referral to the VDC program, medical facility personnel determine the veteran's budget amount using the Purchased Home and Community Based Services Case Mix and Budget Tool (case mix tool). The case mix tool is used to screen for appropriate funding based on the veteran's clinical and functional needs defined by a case mix rate. Figure B.1 shows the components of case mix tool results.

Figure B.1. *Overview of the distribution of case mix tool funds.*
Source: VA OIG analysis of the Office of Geriatrics and Extended Care Veteran Directed Home and Community Based Services Program Procedures and VD-HCBS Billing & Invoicing Procedures Guide: VD-HCBS Aging & Disability Network Providers.

VDC Billing Process

Figure B.2 shows the invoicing process for VDC services. Steps in the billing process that are completed by VHA are in blue, while steps completed by provider agencies and financial management services are in gold.

Figure B.2. *Selected steps in the program billing and invoicing process.*

Source: VA OIG analysis of VD-HCBS Billing & Invoicing Procedures Guide: VD-HCBS Aging & Disability Network Providers.

**If a veteran is determined not to be appropriate for program, the provider agency bills VHA a partial assessment fee.*

Previous Audit Work

The VA OIG and the Government Accountability Office (GAO) have issued 10 reports since 2013 that are relevant to this audit. These reports examined noninstitutional care, the budget process, and the Family Caregiver Program.

- In a November 2020 report, *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*, the OIG reported VHA medical facilities applied program policies differently, or inconsistently prioritized veterans on the program's waiting lists.[69] The team also found variances in how some facility personnel addressed veterans who were difficult to place because of prior inappropriate behavior toward aides.

  These differences resulted in some facilities providing inconsistent access to services for some veterans and were partly caused by limited budget resources. VHA concurred with the OIG's recommendations on program policies and practices, controls for service agencies' licensing and certification, program demand tracking, procedures for hard-to-place veterans, timeliness and program claims payment monitoring, and a review of identified program claims errors. As of March 2021, the OIG had closed one of eight recommendations.

- In a February 2020 GAO report, *Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand*, VA officials reported challenges they had aligning care with where veterans live and pointed to the VDC program as an approach that could provide care to veterans in rural areas with limited access to VA-provided or purchased care.[70] However, the GAO found GEC had not established measurable goals for its efforts to address the geographic alignment of care. VA concurred with the GAO's three recommendations, which included GEC leaders developing measurable goals for its efforts to address key long-term care challenges. As of March 2021, the GAO had not closed these recommendations.

- In a September 2019 report, *VA Needs to Improve Its Allocation and Monitoring of Funding*, the GAO found VHA's allocation models did not use workload data from the most recently completed fiscal year.[71] The models did not use more recent data because officials believed that doing so would not significantly affect allocations. By not using the most recent data available when it made final allocations, VHA's allocations may not have accurately reflected medical facilities' funding needs if they experienced workload

[69] VA OIG, *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*.

[70] GAO, *Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand*, GAO-20-284, February 2020.

[71] GAO, *VA Needs to Improve Its Allocation and Monitoring of Funding*, GAO-19-670, September 2019.

changes. VA generally concurred with the GAO's five recommendations, including that VHA use the most recent workload data and require regional networks to explain allocation changes. As of March 2021, the GAO had not closed these recommendations.

- In a September 2019 report, *Actions Needed to Improve Family Caregiver Program*, the GAO reported VHA established staffing requirements for its Family Caregiver Program that allow for variation, but its staffing data were neither complete nor accurate.[72] VHA medical facilities could also fund additional program staff or have other facility staff assist the program as a collateral duty, but the GAO found that the program office only tracked the staff it funded. The GAO also identified discrepancies between the number of staff it observed at selected medical facilities and the program office's staffing data.

  Without complete and accurate staffing data, the program office did not have reliable information about the program's current staffing levels, which could hamper its efforts to project needed staff when the program's eligibility expanded. The program office routinely monitored medical facilities' performance in meeting departmental timeliness requirements for reviewing enrollment applications for the Family Caregiver Program. However, it was not able to monitor whether medical facilities were completing required quarterly contacts and annual home visits to enrolled caregivers and veterans. The GAO made three recommendations to VA to collect complete staffing data, establish a process to ensure the data are accurate, and establish an interim method for collecting system-wide data on required contacts and visits. VA concurred with all three recommendations. As of March 2021, the GAO had closed one of these recommendations.

- In a July 2019 report, *Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement*, the OIG found that VHA nearly always acted in a timely manner to discharge veterans and caregivers from the program and cancel caregiver stipends.[73] However, in about 6 percent of the cases, veterans and caregivers were not discharged in a timely manner, causing VHA to pay at least $356,000 in improper and questionable caregiver stipends. If program controls were not improved, the team estimated VHA could pay $583,000 in improper stipends over five years.

  VHA generally concurred with the OIG's recommendations to establish processes to match records of enrolled veterans and their caregivers against the VA's death, incarceration, and hospitalization data on a regular basis; outline veteran and caregiver responsibilities for promptly notifying their caregiver support coordinator of deaths; and

[72] GAO, *Actions Needed to Improve Family Caregiver Program*, GAO-19-618, September 2019.

[73] VA OIG, *Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement*.

institute a working group to clarify inconsistencies and gaps in program guidance. The OIG closed all three recommendations.

- In a June 2019 report, *Estimating Resources Needed to Provide Community Care*, the GAO reported VA used a projection model to estimate the majority of resources needed to provide health care services.[74] Beginning with the President's FY 2018 budget request, VA updated its model to estimate the resources needed to purchase over 40 community care services accounting for over 75 percent of VA's community care budget estimate. These services included outpatient and inpatient care. For the remainder of its community care budget estimate, which included nursing care in state-operated homes, VA used other methods based on historical utilization. VA identified several changes made during the review process to its budget estimate for FYs 2018 and 2019 to reflect more current information related to utilization and costs. The GAO made no recommendations.
- In the August 2018 report, *Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed*, the OIG determined VHA discharged veterans without consistently monitoring their health conditions.[75] Clinicians and program coordinators either did not adequately document the extent to which veterans' health conditions changed in their electronic health records or failed to routinely monitor these veterans and their caregivers before the clinical reassessments that led to discharge from the program.

  In total, the OIG questioned about $41.6 million that VHA paid to caregivers of veterans discharged from the program from January through September 2017 because the required monitoring to determine ongoing eligibility for the program was not performed. VHA generally agreed with the OIG's six recommendations related to eligibility determinations, monitoring, staffing, and governance. The OIG closed all of these recommendations.
- In the September 2014 *Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program* report, the GAO reported VHA significantly underestimated caregivers' demand for services when it implemented the Family Caregiver Program.[76] As a result, some VA medical centers had difficulties managing the larger-than-expected workload, and some caregivers experienced delays in approval determinations and in receiving program benefits. The report noted that VHA had taken some steps to address staffing shortages; however, some facilities had not been able to overcome their workload problems because the program continued to grow at a steady

[74] GAO, *Estimating Resources Needed to Provide Community Care*, GAO-19-478, June 2019.

[75] VA OIG, *Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed*.

[76] GAO, *Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program*, GAO- 14- 675, September 2014.

rate. Federal internal control standards emphasize the need for effective and efficient operations, including the use of agency resources.

The GAO recommended that VA expedite the process for implementing a new IT system to enable officials to obtain workload data. The GAO also recommended that VHA identify solutions to alleviate facilities' workload burden in advance of obtaining a new IT system, and use data from the new IT system, once implemented, and other relevant data, to reassess the program and implement changes as needed. VA agreed with the GAO's recommendations. As of March 2021, the GAO had closed one of these recommendations.

- In the September 2013 *Audit of Selected Non-Institutional Purchased Home Care Services* report, the OIG estimated VHA's waiting lists did not include at least 49,000 veterans who had purchased home care services in FY 2012.[77] The OIG also projected that 114 VA medical facilities limited access to purchased home care services by using more restrictive eligibility criteria than VHA policy required, applying nonstandard review processes, and relying on inaccurate and nonstandard eligibility information.

  VA medical facilities' staff also did not identify 31 ineligible agencies and properly manage 19 high-risk agencies. Fee staff did not always verify billings before paying for services, resulting in $67,000 in improper payments. Without actions to strengthen controls, VHA was at risk of paying ineligible agencies about $893.5 million and making about $13.2 million in improper payments over the five years after the report's issuance. VHA concurred with the OIG's recommendations about eligibility criteria, waiting lists, program oversight, and performance measures. The OIG closed all eight recommendations.

- In the August 2013 report, *Improvements Made, but Additional Actions Needed to Address Problems Related to Estimates Supporting President's Request*, the GAO reported VA expanded the use of the Enrollee Health Care Projection Model in developing the agency's healthcare budget estimate that supported the President's FY 2014 budget request.[78] VA expanded the use of the model by using, for the first time, the model's estimate for the amount of care provided—workload—to develop estimates of the resources needed for 14 long-term care services. However, VA continued to use the most current expenditure data rather than model estimates for projecting needed resources for these services due to concerns about the reliability of model expenditure

[77] VA OIG, *Audit of Selected Non-Institutional Purchased Home Care Services*, Report No. 11-00330-338, September 30, 2013.

[78] GAO, *Improvements Made, but Additional Actions Needed to Address Problems Related to Estimates Supporting President's Request*, GAO-13-715, August 2013.

data. VA concurred with the GAO's recommendations about using consistent terminology to label estimates for administrative personnel costs and providing consistent and comprehensive information explaining the costs in each budget category for administrative costs. The GAO closed these two recommendations.

Appendix C: Statistical Sampling Methodology

Approach

To accomplish the audit objective, the audit team reviewed a random statistical sample of veterans in the VDC program who received program services between July 1, 2019, and April 30, 2020. The team used criteria identified during a review of VDC program guidance to identify veterans receiving program services. The team used procedural codes T1020 and T2024 and Purpose of Visit Code 27 to identify claims associated with VDC services.

Population

The audit team obtained claims data from VHA's Corporate Data Warehouse and OIG's Data Analysis Division. The target population for the audit included VDC claims with dates of service from July 2019 through June 2020. The team identified all available program claims and randomly selected a sample of program claims with procedural codes T1020 and T2024 and Purpose of Visit Code 27. The team used each unique veteran as the base unit of analysis. The sampling frame consisted of 3,928 veterans with procedural codes T1020 or T2024 or Purpose of Visit Code 27 and dates of service from July 1, 2019, through April 30, 2020. Of these veterans, an estimated 3,858 received VDC services. The sampling frame dates do not match the dates of the target population because the database with veteran claims was not complete at the time it was accessed because of delays in processing these claims and the timing of the team's sampling in May 2020. Since the exact number could not be determined due to factors including participants entering and leaving the program during the audit review period, the team estimated the population of veterans who received VDC services.

Sampling Design

The audit team identified that some VDC claims were for a full month of service. However, there were provider agencies that submitted more than one claim for a full month of service. Therefore, the team aggregated groups of claims (all claims for a specific veteran during a specific month) as sampling units for review and analysis. For purposes of this appendix, the term "claim" will refer to a selection of claims grouped in this way. The team selected a statistical random sample of 70 claims from the population of unique veterans, which resulted in 68 unique veterans being selected in the review sample. Two veterans had two claims selected in the sample.

The audit team used dates of service to identify program claims instead of claim submission dates or the dates the claims were paid. Provider agencies may submit claims at various times after services are rendered. Using dates of service allowed the team to review services rendered across the audit review period.

The audit team reviewed claims data and documentation provided by VHA for each of the 68 veterans in the sample to assess how VHA managed VDC resources to ensure veterans received authorized home and community-based goods and services. The team conducted an additional review of the veterans enrolled in both the VDC and Family Caregiver Programs. Of the 3,928 veterans in the sampling frame, 558 veterans were 60 years old or younger and therefore potentially eligible for the Family Caregiver Program. The team identified 46 participants who were enrolled in both the VDC and Family Caregiver Programs during one or more months from May 2011 through September 2020. Of these 46 veterans, 42 received services from both programs during at least one month in FY 2020. The team estimated costs for this overlapping coverage in FY 2020 based on the lesser payment amount between the VDC monthly budget amounts and the Family Caregiver Program stipend payments. Table C.1 summarizes the team's findings.

Table C.1. VDC Participants in the Family Caregiver Program

VDC participants	Number
Total	**3,928**
Eligible for the Family Caregiver Program	558
Received services from both the VDC and Family Caregiver Programs during one or more months of FY 2020	42

Source: VA OIG analysis of VDC and Family Caregiver Programs' enrollment data.
Note: These data reflect the audit team's analysis using Family Caregiver Program criteria as of September 2020. The 42 veterans in the table represent veterans who had overlap between the VDC and Family Caregiver Programs for at least one month in FY 2020. The results do not reflect the expansion of the Family Caregiver Program, which began in October 2020.

Projections and Margins of Error

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the audit team repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement does not significantly change as

more records are added to the sample review. Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

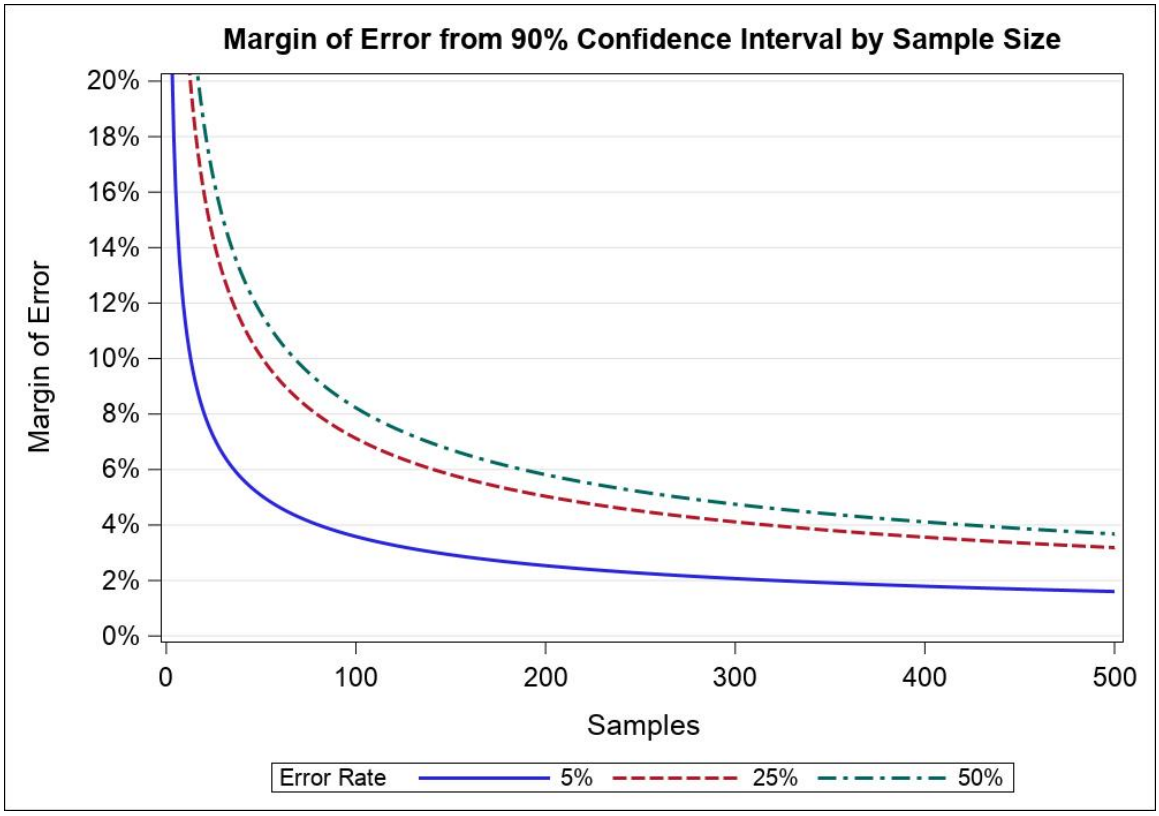

Figure C.1. *Effect of sample size on margin of error.*
Source: VA OIG statistician's analysis.

Estimation Methodology for VDC Program Enrollment and Claims

The audit team reviewed 68 veterans who received VDC services during the audit review period (July 1, 2019, to April 30, 2020). The team used each unique veteran as the base unit for analysis for this review. The team assessed each area of review for all 68 veterans in the sample.

The projections in the statistics tables are based on the sampling frame used for this audit. Ideally, the records in this sampling frame would include all claims for the one-year period from July 2019 through June 2020. However, data for the audit were sampled at the end of May 2020, so no VDC services for June were available. In addition, data were missing from the databases for all of May and for part of several earlier months, as shown in figure C.2. The missing records are a result of lag time between (1) the date of service for a claim, and (2) the date its status is resolved and the database is updated. Because of these delays, the 3,928 veterans and 23,632 veterans' claims in the sampling frame underrepresent the corresponding numbers in the population.

Although the incompleteness of the sampling frame likely had little impact on error rate projections (there is no reason to expect that missing records would have a different error rate from present records), it significantly affects monetary estimates and estimates of the total number of veterans being underpaid. It is therefore appropriate to adjust these projected values to account for expected actual population size. The adjustments are based on the underlying values for figure C.2. In this figure, each bar represents the number of veterans in the sampling frame with a claim during a particular month. Bars are formatted to show the number of veterans in each enrollment category:

- **First month**: veterans whose first claim in the sampling frame occurred during the month
- **Subsequent months**: veterans whose first claim in the sampling frame occurred during a previous month

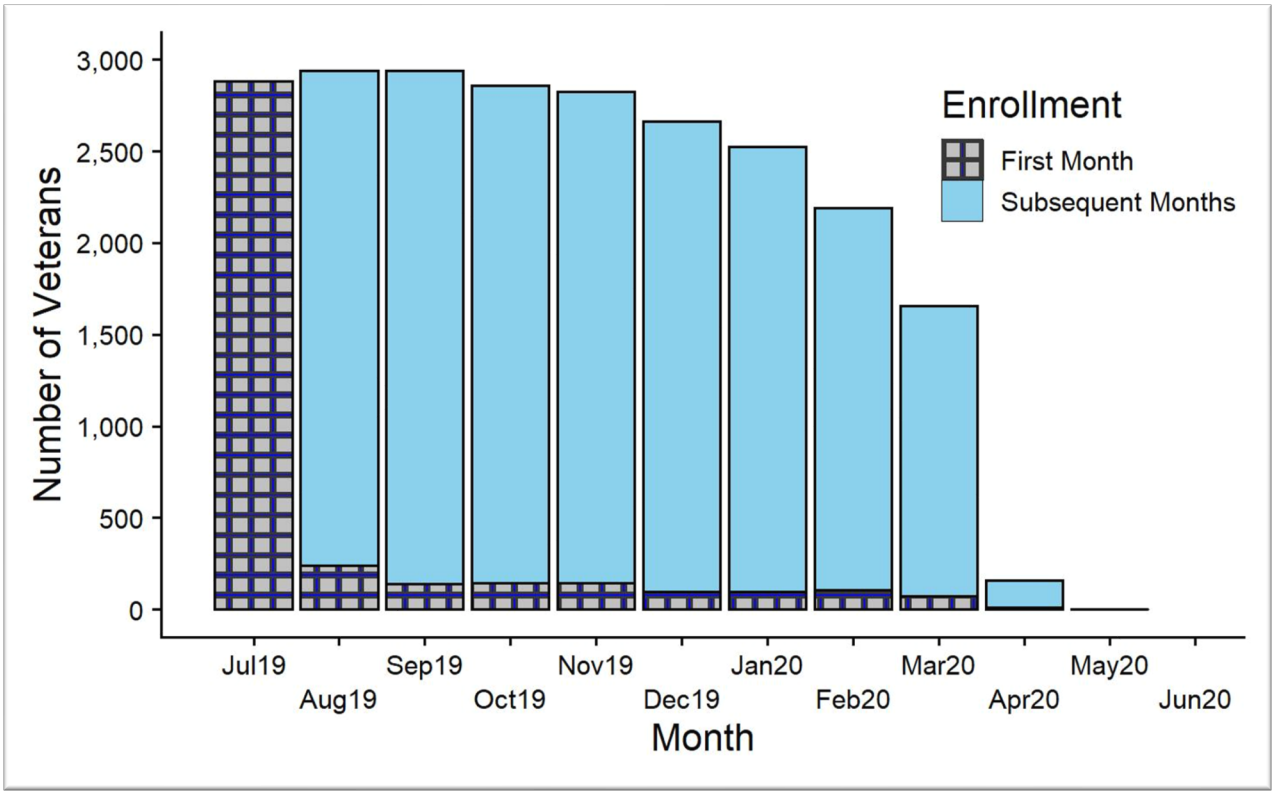

Figure C.2. *Number of veterans' VDC claims during the audit review period.*
Note: Because of the date in which the sample was obtained and the lag between dates of service and database updates, the sampling frame became progressively incomplete from December 2019 through June 2020.
Source: VA OIG statistician's analysis of VDC program claims.

To adjust the number of veterans' claims in the population, the average number of claims from September through November was calculated and applied to the months from December through June. This calculation resulted in an estimated number of veterans' claims of 34,564 that would have been in a complete sampling frame (up from 23,632 in the actual, incomplete sampling

frame, an increase of about 46.3 percent). Accounting for estimated out-of-scope claims, the number of claims in the population is estimated to be 33,624.

To estimate the number of unique veterans in the population, the average number of "first month" veterans from September through November was calculated and applied to the months from December through June. This calculation resulted in an estimated number of unique veterans of 4,170 that would have been in a complete sampling frame (up from 3,928 in the sampling frame, an increase of about 6.2 percent). Accounting for estimated out-of-scope veterans, the number of veterans in the population is estimated to be 4,097.

Table C.2 details the audit projections related to VDC claim underpayments. The estimate number and one-sided lower bound provide projection estimates based on the number of veterans in the sampling frame. The adjusted one-sided lower bound accounts for the actual population calculation described above.

Table C.2. Statistical Projections Summary for Underpayments for VDC Program Participant Review*

Estimate name	Estimate number (adjusted estimates)	Margin of error	Confidence interval lower limit	Confidence interval upper limit	One-sided confidence interval lower limit (adjusted estimates)
Program claims that were not underpaid	80.1%	8.5%	72.7%	89.6%	74.0%
Program claim underpayments	19.9%	8.5%	12.4%	29.4%	13.8%
Number of claims that were not underpaid	18,413 (26,938)	1,814	16,599	20,227	17,005 (24,878)
Number of underpaid claims	4,570 (6,686)	1,814	2,756	6,384	3,162 (4,626)
Total value of underpaid claims	**$5,897,351 ($8,627,825)**	**$3,295,671**	**$2,601,680**	**$9,193,022**	**$3,339,733 ($4,886,030)**

Source: VA OIG analysis of a random sample of 70 program claims for 68 veterans from July 1, 2019, through April 30, 2020.
**These calculations are based on an estimated 33,624 program claims.*
Note: Margin of error and confidence bounds are reported with 90 percent confidence. The sample size for these estimates was 70. There is no adjusted estimate for the proportions for program claim underpayments because any change in the number of veterans is offset by an equivalent change with the number of errors. Because of the high margin of error for total value of underpaid claims, projections in this report are provided with respect to the adjusted one-sided lower bound. Numbers in the table were rounded for reporting purposes.

Table C.3. details the audit projections related to VA quarterly monitoring. The number of estimated veterans with errors is 1,526, which was adjusted to be an estimated 1,621 as shown in table C.3.

Table C.3. Statistical Projections Summary for Monitoring for VDC Program Participant Review*

Estimate name	Estimate number (adjusted estimate)	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
VHA monitoring not documented	39.6%	12.1%	28%	52.1%	68
Number of veterans without documented VHA monitoring	1,526 (1,621)	464	1,081	2,010	68

Source: VA OIG analysis of a random sample of 70 program claims for 68 veterans from July 1, 2019, through April 30, 2020.
**These calculations are based on an estimated 4,097 veterans.*
Note: There is no adjusted estimate for the proportions for VHA monitoring not documented because any change in the number of veterans is offset by an equivalent change with the number of errors. Numbers in the table were rounded for reporting purposes.

Estimation Methodology for Potential Cost Savings

The audit team further identified and reviewed 42 veterans who received similar personal care services from the VDC and Family Caregiver Programs during the same period. This analysis was limited to those veterans who received similar services from both the VDC program and the Family Caregiver Program in FY 2020 (October 2019 through September 2020). For each month in which a veteran received benefits from both programs, the team tabulated the lesser of the VDC monthly budget amount and the Family Caregiver Program stipend payment. Because the lesser amount was used in all cases, the sum of these tabulated amounts is a conservative estimate of the potential savings amount for all of these veterans.

Cost Saving Estimates for Veteran Groups by Age

Having obtained the cost savings for veterans 60 years old and younger, the cost savings for veterans 61 years old and older was estimated by assuming that the average cost savings for veterans in both age categories are similar. Given this assumption, data for the veterans 60 years old and younger were used to estimate the mean cost savings for veterans 61 years old and older. This estimated mean value, along with the number of veterans 61 years old and older in the

sampling frame, was used to project total cost savings for veterans 61 years old and older over a period of one future year following complete expansion of the Family Caregiver Program.

By summing the calculated costs savings for veterans 60 years old and younger and the estimated costs savings for veterans 61 years old and older, the team obtained a combined estimate of cost savings of approximately $6.2 million for veterans of all ages during a future year. This sum was then adjusted to at least approximately $6.6 million ($933,371 + $5,637,024 = $6,570,395) annually to account for the incompleteness of the sampling frame used for this analysis, as described above and depicted in figure C.2. Table C.4 identifies the team's projections for these veterans.

Table C.4. Statistical Projections Summary of Cost Savings for VDC and Family Caregiver Program Participant Review

Estimate name	Estimate number (adjusted estimates)	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Population size
Cost savings (veterans who are 61 years old or older)	$5,307,933 ($5,637,024)	$1,431,807	$3,876,126	$6,739,739	3,370
Cost savings (veterans who are 60 years old or younger)	$878,880 ($933,371)	---	---	---	558
Total cost savings (all veterans)	**$6,186,813 ($6,570,395)**	**$1,428,973**	**$4,755,006**	**$7,618,620**	**3,928**

Source: VA OIG analysis of 42 veterans receiving services from the VDC and Family Caregiver Programs concurrently in FY 2020.
Note: The cost savings for veterans who are 60 years old or younger represent the actual estimate number and population size for this analysis. The cost savings of $878,880 represents the exact calculation for the entire population. Therefore, there are no associated intervals. Numbers in the table were rounded for reporting purposes.

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
5 and 6	Potential savings related to veterans enrolled in the VDC and Family Caregiver Programs at the same time who receive similar personal care services with the expansion of the Family Caregiver Program.	$6,570,395	
	Total	**$6,570,395***	

** The audit team estimated at least $6,570,395 by using the lesser of the VDC and Family Caregiver Programs' monthly payment amounts as the cost that VHA could have avoided per veteran per month. With the help of a VA OIG statistician, the team calculated the total cost avoidance for all veterans with payment overlaps in a one-year period. To do so, the team summed $933,371 in potential cost savings for personal care services for veterans 60 years old or younger, and $5,637,024, which is an estimate of payments for these services for veterans 61 years old or older ($933,371 + $5,637,024 = $6,570,395). The numbers in this appendix were rounded for reporting purposes. Appendix C provides details on the audit's statistical sampling methodology, projections, and margins of error.*

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: June 14, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report-Opportunities Exist To Improve Management of Noninstitutional Care Through The Veteran-Directed Care Program (2020-02828-R1-0003) (VIEWS #05252597)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report on the Veteran-Directed Care Program (VDC).

2. VDC provides Veterans with more choice and control over their home care than any other Geriatrics and Extended Care Program. Veterans in VDC design individualized spending plans to meet their needs and decide who provides care, when it is provided, and how it is provided. Of the 70 Veterans Affairs (VA) medical centers that proactively implemented VDC, six of them already have over 200 enrolled Veterans and many others have exceeded 100 enrollees.

3. The Federal partnership between Veterans Health Administration (VHA) and the Administration for Community Living (ACL) is a model collaboration between Federal agencies that leverages both VHA's and ACL's networks to better serve Veterans and provide them with opportunities to live at home independently.

4. A recent VA Health Services and Research Development sponsored evaluation of VDC substantiated reports from VA facilities that VDC lowers hospitalizations, emergency room visits, and nursing home admissions. In addition, these beneficial effects are even more prominent for Veterans in rural areas.

5. VHA concurs with recommendations 1-2 and 4-8. VHA concurs in principle with recommendation 3 and provides an action plan to address all recommendations.

The OIG removed point of contact information prior to publication.

Richard A. Stone, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

VA HEALTH CARE: Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program

Date of Draft Report: May 21, 2021

Recommendations/Actions Status Completion Date

Recommendation 1. The Under Secretary for Health should establish a process to ensure program personnel document veterans' quarterly monitoring in their electronic health records, such as by using a standardized template.

Comments: Concur.

The Office of Geriatrics and Extended Care (GEC) will re-affirm the monitoring standard in its published procedures and develop a standardized template for the electronic health record (EHR).

Status: In progress Target Completion Date: December 2021

Recommendation 2. The Under Secretary for Health should establish a process to ensure the provider agency list in the Electronic Claims Adjudication Management System is updated as new provider agencies are added to the program.

Comments: Concur.

GEC will establish an internal procedure, as part of the new provider agencies on-boarding process, to provide Payment Operations Management (POM) and the Financial Services Center in Austin with the necessary information to ensure timely payment of claims.

Status: In progress Target Completion Date: August 2021

Recommendation 3. The Under Secretary for Health should establish a process to ensure claims processors apply proper pricing in the Electronic Claims Adjudication Management System when paying program claims.

Comments: Concur in principle

The Veterans Health Administration (VHA) Office of Community Care (OCC) recognizes the importance of paying claims accurately. VHA finds it is important to clarify that the errors identified in this audit, resulting from OCC claims processors selecting incorrect rates, occurred in the Fee Basis Claims System (FBCS) not the Electronic Claims Adjudication Management System (eCAMS). FBCS is no longer in use. Unlike FBCS, in eCAMS claims processors do not manually select a payment methodology; therefore, it is not necessary to establish a process to ensure claims processors apply proper pricing in eCAMS.

The accurate payment of Veteran Directed Care (VDC) claims is dependent on the presence of a current and accurate provider agency list in eCAMS. The eCAMS errors identified in this audit resulted when providers were not loaded into eCAMS. When eCAMS does not recognize a provider, the system automatically follows the payment methodology hierarchy, which can result in paying less than billed charges. GEC is working on the recommendation from this audit that addresses the provider agency list findings. OCC will collaborate with GEC as necessary on this issue. Claims processors do not apply pricing in eCAMS and the eCAMS logic is paying correctly when the system has the correct provider agency list information loaded.

Status: In Progress Target Completion Date: August 2021

Recommendation 4. The Under Secretary for Health should update program guidance on claims submission and processing to make sure provider agencies are aware of the need to include all required information when submitting program claims.

Comments: Concur

The Administration for Community Living completed updates to billing guidance in May and it was reviewed by VHA's POM. With the completion of these updates, training for provider agencies will be conducted in June 2021.

Status: In progress Target Completion Date: July 2021

Recommendation 5. The Under Secretary for Health should establish guidance to include processes that medical facilities must follow to determine if veterans are receiving the same personal care services through the Veteran-Directed Care program and the Program of Comprehensive Assistance for Family Caregivers, and how to address these situations, as appropriate.

Comments: Concur.

Guidance on avoiding potential duplication of services, when VDC and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) are concurrent, has been developed. Training for GEC and PCAFC staff was completed in April and May 2021. A memo to the field is presently under development to ensure each facility is aware of these new requirements in addressing duplication of services.

Status: In progress Target Completion Date: August 2021

Recommendation 6. The Under Secretary for Health should ensure program personnel determine if veterans enrolled in both the Veteran-Directed Care and the Program of Comprehensive Assistance for Family Caregivers are receiving the same personal care services and take action, as appropriate.

Comments: Concur.

Guidance on potential duplication of services, when dual enrollment in VDC and PCAFC occurs, will include review requirements at PCAFC enrollment, when there is a significant change in the Veterans condition and annually. The guidance includes specific actions to be taken when duplication of services is found.

Status: In progress Target Completion Date: August 2021

Recommendation 7. The Under Secretary for Health should establish procedures to identify program staffing needs and define program personnel's roles and responsibilities at the national, network, and local levels.

Comments: Concur.

GEC is working with OCC on a staffing model for all Purchased Long Term Services and Supports programs, including VDC. Roles and responsibilities for each level to include national, Veterans Integrated Service Networks and facilities will be included in a procedures document.

Status: In progress Target Completion Date: May 2022

Recommendation 8. The Under Secretary for Health should update procedures for tracking and reporting demand for and use of program services and use these data to inform yearly cost estimates for the program.

Comments: Concur

GEC will develop a broad review and an internal procedure to estimate demand for VDC and use this information, including unable to schedule data, for budget development.

Status: In progress Target Completion Date: February 2022

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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