



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Homemaker and Home
Health Aide Program:
Most Claims Paid Correctly,
but Opportunities Exist to
Improve Services to
Veterans

AUDIT

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Executive Summary

Many older veterans have multiple health concerns, live alone, or are isolated from their communities. The Veterans Health Administration (VHA) provides these vulnerable veterans with services that allow them to remain in their homes for as long as possible. 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. Homemaker aides assist with instrumental activities of daily living such as light housekeeping, laundering, and grocery shopping. Home health aides provide hands-on help with activities of daily living such as feeding, dressing, and exercising.

VHA referrals for home healthcare services are made to home health agencies that are state-licensed or certified by the Centers for Medicare and Medicaid Services for the level of care provided. In addition, all VHA purchases of home health care will be made only from licensed and appropriately certified agencies in good standing with their state licensing bodies.¹ In 2014, the assistant deputy under secretary for health for clinical operations issued a memorandum that noted all agencies participating in the program will have a state license to provide program services and are responsible for meeting state standards or certain conditions.² These requirements, if implemented correctly, should provide VHA reasonable assurance that veterans are receiving program services as intended.

VHA's budget for homemaker and home health aide services has nearly doubled since fiscal year (FY) 2014. The number of veterans using homemaker and home health aide services increased from about 84,300 veterans in FY 2014 to about 136,000 veterans in FY 2019. In FY 2019, more than a third of the veterans who received homemaker and home health aide services were 85 years old or older. While VHA program guidance does not require home health agencies to submit supporting documentation (such as timesheets) to justify charges, federal standards for internal controls recommend that all transactions be clearly documented and readily available for examination.³ Without sufficient documentation, VHA does not have a control to ensure that veterans in fact received intended services from agencies.

The Office of Inspector General (OIG) conducted an audit of this program due to the large number of veterans enrolled; the high cost; the risks experienced by older veterans, such as loss of autonomy, poor health, and social isolation; and the volume and nature of OIG hotline

¹ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

² VHA, Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services," May 23, 2014.

³ VHA Handbook 1140.6; VHA, Office of Community Care, "VA Community Care Standard Operating Procedure," June 2018; and Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-70G, September 2014.

complaints received.⁴ The audit objective was to determine if veterans received intended homemaker and home health aide program services, and whether VHA accurately processed program claims.

What the Audit Found

The audit team found VHA lacked assurance that veterans received intended homemaker and home health aide services. VHA cannot be certain that veterans received program services from home health agencies that, when required, were licensed or certified. In addition, VHA lacked awareness of medical facilities that applied program policies and practices differently or prioritized veterans on program electronic waiting lists inconsistently. Although the team found VHA paid over half of program claims on time and almost always accurately, opportunities exist for VHA to reduce its risk of paying for claims that were not authorized in advance or for services that were not provided to veterans.

VHA Lacks Assurance That Veterans Received Services from Licensed or Certified Home Health Agencies When Required

The audit team analyzed a random sample of 200 program claims submitted by 177 home health agencies from September 2018 through February 2019. Based on the findings, the team estimated that of the about 1.1 million claims approved for payment, VHA processed approximately 546,000 claims by unlicensed and uncertified home health agencies.⁵ The team also estimated VHA made up to \$145.4 million in improper payments to home health agencies without valid licenses or certifications during the same period.⁶ Medical facility directors are responsible for verifying in annual reports that home health agencies are in good standing with state licensing and certifying agencies.⁷ While medical facilities are allowed to exempt or locally approve agencies that meet the conditions in VHA guidance, they may not have reported this information as required. Medical facilities' use of unlicensed or uncertified agencies puts veterans at risk of receiving care that does not meet program standards. According to the team's

⁴ In the last five years, the OIG received 17 hotline complaints related to the program. Most of these complaints alleged unfair program eligibility, potential fraud, and delays in home health agencies getting paid on time.

⁵ The review period was the six months prior to the start of the audit in March 2019. The review period was selected to ensure the audit team's findings and recommendations were based on current data. Appendix B provides additional details on the audit scope and methodology. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit.

⁶ Office of Management and Budget, Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. This circular defines an improper payment as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Appendix B provides additional details on the improper payments made to home health agencies without valid licenses or certifications during the review period. Appendix E details the team's potential monetary benefits calculations.

⁷ VHA Handbook 1140.6.

May 2019 survey of facility personnel responsible for the daily management of the program, only about 35 percent reported they provide facility directors with quality management reports. As a result, some facility directors lack assurance that veterans are receiving care from home health agencies that, when required, are licensed or certified.

Some Facilities Applied Program Policies and Practices Differently

VHA Handbook 1140.6 directs how VHA purchases homemaker and home health aide services through home health agencies in the community. Veterans are eligible to receive program services if they are enrolled in VHA for their health care and are “in need of nursing home care.”⁸ This guidance reflects the Veterans’ Health Care Eligibility Reform Act of 1996, which extended program eligibility to nonservice-connected disabled veterans.⁹ VHA must offer program services to a veteran if an interdisciplinary clinical team determines that the veteran needs nursing home care. The criteria used to identify eligible veterans who are most in need of program services include the need for assistance in performing various daily living activities, significant cognitive impairment, and other combinations of factors such as frequent hospitalizations, age, living alone, hospice support, and clinical considerations.¹⁰

Medical facility directors are required to establish facility policies and practices for the referral, planning, and monitoring of program services.¹¹ Of 100 medical facilities with local policies or practices, the audit team identified 22 facilities with requirements not specified in VHA guidance. These requirements may unintentionally affect veterans’ access to program services, including the number of allowed service hours. For example, one facility required an additional eligibility review that included an assessment completed by a social worker of the veteran’s living situation and a justification for services. The team determined that these additional requirements resulted in inconsistent access to program services for veterans in different communities. As a result, actual demand for these services may be underrepresented to VA.

⁸ As stated in VHA Handbook 1140.6, veterans who meet the requirements under title 38 of the Code of Federal Regulations § 17.37 are not required to be enrolled in VHA for their health care to be eligible to receive program services.

⁹ Veterans’ Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262 (1996). Disability compensation is a monetary benefit paid to veterans who are determined by VA to be disabled by an injury or illness that was incurred or aggravated during active military service. Veterans who receive disability compensation are considered to be service connected.

¹⁰ VHA Handbook 1140.6.

¹¹ VHA Handbook 1140.6. Forty-one program personnel from 141 facilities reported through the OIG audit team’s survey that they did not have a local program policy, used the Handbook rather than a local policy, or used a combination of national policy and VHA Community Care guidance to operate their programs. The team could not confirm whether veterans at facilities without written local policies were provided access to program services consistent with facilities that had written policies.

Medical Facilities' Management of Electronic Waiting Lists for Program Services Varied

VHA is required to decide on the suitability of a veteran for homemaker and home health aide services within seven days of receiving a consult.¹² A consult is a request for opinion, advice, or expertise from one healthcare provider to another regarding the evaluation or management of a patient's specific problem.¹³ However, some medical facilities did not meet this requirement. As a result, eligible veterans may experience delays in being scheduled for program services. According to VHA Handbook 1140.6, facilities should prioritize veterans who are in nursing homes or need nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rating of 50 percent or more.¹⁴ Although veterans may be found administratively eligible to receive homemaker and home health aide services, if VHA is unable to provide those services due to insufficient budget resources, then veterans should be placed on an electronic waiting list. While the Handbook addresses electronic waiting list prioritization in regard to budget resources, it does not reflect what facilities should do when home health agencies in the community cannot meet facilities' demand for homemaker and home health aide services. In 2014, VHA issued a memorandum requiring the use of electronic waiting lists any time home health services cannot be immediately arranged.¹⁵ However, the Handbook has not been updated to address how facilities should prioritize veterans on waiting lists for nonbudgetary reasons as specified in the memorandum.

Facility personnel reported that the most frequent reasons for placing veterans on electronic waiting lists were the lack of homemaker or home health aide staff, a limited supply of agencies providing needed services near a veteran's home, and an increase in the number of veterans enrolled in the program. In addition, in response to the audit team's survey, 20 medical facilities that reported having veterans on waiting lists were found to be prioritizing these veterans differently, or not prioritizing them at all.

VHA also did not have a way to accurately track the number of veterans on waiting lists for homemaker and home health aide services. Medical facilities use the same numeric code to track services available through several programs, including the homemaker and home health aide program. For example, the code that VHA uses to track these veterans is also used for veterans waiting for other services. Therefore, VHA could not effectively monitor each medical facility's

¹² VHA, 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.

¹³ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

¹⁴ A rating percentage is a multiple of 10 percent that indicates the severity of the disability and how much it diminishes the veteran's health and ability to function.

¹⁵ VHA, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services."

capacity to meet veteran demand for specific services and determine whether additional program funding is needed.

VHA Paid More Than Half of Program Claims within 30 Days and Nearly Always Accurately, but Opportunities Exist for Improvements

VHA paid more than half of homemaker and home health aide program claims within 30 days and nearly always paid them accurately. Of the 1.1 million claims approved for payment from September 2018 through February 2019, the audit team reviewed 200 randomly selected claims. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018), which was signed into law in June 2018, includes a prompt payment standard that electronic claims are paid within 30 calendar days upon receipt of the claim.¹⁶

From September 2018 through February 2019, VHA paid an estimated 598,000 claims (or about 54 percent) within 30 days of being submitted by a home health agency.¹⁷ However, homemaker and home health aide agency representatives reported concerns about their agencies' ability to continue to do business with VHA when payments for program services already provided to veterans are not promptly paid.

The audit team estimated that VHA improperly paid at least \$8.5 million to home health agencies, with at least \$5.5 million of this amount potentially recoverable.¹⁸ The improper payment estimates are based on 19 of 200 randomly selected program claims that the team found were deficient due to reasons such as authorization errors, duplicate payments, and unsupported claims with overpayments.¹⁹ Opportunities exist for VHA to reduce its risk of paying for inadequately supported claims or claims for services that were not authorized in advance.

What the OIG Recommended

The OIG made eight recommendations to the under secretary for health that included assessing the sufficiency of program policies and practices, improving service agencies' licensing and

¹⁶ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, Pub. L. No. 115-182, § 111 (2018). The team considered all program claims reviewed to be electronic, as this analysis was based on the date program claims were added to the Fee Basis Claims System.

¹⁷ As detailed in the report, the 30-day measure used is similar to the measure in the VA MISSION Act of 2018. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit that relate to estimations.

¹⁸ Office of Management and Budget, Circular A-123. The Office of Community Care made improper payments when it made payments that should not have been made or that were made in an incorrect amount under applicable legal requirements.

¹⁹ The team considered four deficient claims to be unsupported and not recoverable.

certification controls, leveraging data on veteran program demand, developing procedures for hard-to-place veterans, reviewing identified claim errors and taking corrective action as necessary, assessing the timeliness of service decisions and claim payments, and mitigating the risk of claim payment errors by ensuring sufficient monitoring of this process.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the recommendations and provided corrective action plans that are responsive to the intent of the recommendations. The executive in charge reported VHA took action to address the recommendation to improve controls over service agencies' licensing and certification requirements and requested the OIG consider closing this recommendation. The OIG reviewed VHA's response to improve licensure and certification controls and considers this recommendation closed. The OIG will monitor the implementation of planned actions and will close the remaining recommendations when VHA provides enough evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix D includes the full text of the executive in charge's comments.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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Abbreviations

FBCS	Fee Basis Claims System
FY	fiscal year
GEC	Office of Geriatrics and Extended Care
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The Veterans Health Administration's (VHA) homemaker and home health aide program offers personal care and related services to help frail or disabled veterans with their daily activities. Homemakers and home health aides are not nurses and are required to be under the general supervision of a registered nurse.²⁰ The program is among the largest programs VHA operates to provide veterans with care in their homes and is growing dramatically.

According to VHA, the number of veterans using program services increased from about 84,300 veterans in fiscal year (FY) 2014 to about 136,000 veterans in FY 2019 and the program budget nearly doubled. Table 1 shows how much VHA spent on program services from FYs 2014 through 2019. VHA's program budget for FY 2020 is slightly more than \$1 billion.

Table 1. VHA Spending on Program Services for FYs 2014 through 2019

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
VHA spending in millions	\$429	\$721	\$595	\$723	\$870	\$844*
Percentage change from the previous FY	—	68%	(17%)	22%	20%	(3%)

Source: VA Budget Submission—Medical Programs and Information Technology Programs from FY 2016 through 2020 and VHA Support Service Center data as of October 2019.

Note: VA's budget for homemaker and home health aide services also includes funding for veteran-directed care program services. The veteran-directed care program allows a veteran, or his or her caregiver, to manage a monthly budget to purchase goods and services to help the veteran with activities in the home. Numbers in the table were rounded for reporting purposes.

*As of October 2019, VHA reported spending about \$775.9 million on homemaker and home health aide services and about \$67.8 million on veteran-directed care program services in FY 2019. VA's spending for these two programs is reported together for the homemaker and home health aide program budget.

VHA reported about 128,000 male veterans and approximately 7,800 female veterans used program services in FY 2019.²¹ Almost all male veterans (115,000) enrolled in the program were 65 years old or older. In contrast, only slightly more than half of the female veterans (4,600) enrolled in the program were 65 years old or older. Table 2 identifies the ages of veterans who received program services in FY 2019.

²⁰ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

²¹ The sum of the male and female veterans participating in the program during FY 2019 will not match the sum of the veterans participating in the program detailed by age in table 2. The differences in the totals are due to rounding.

**Table 2. Number of Veterans Who Used Program Services
in FY 2019 by Age**

	Less than 65 years old	65 to 74 years old	75 to 84 years old	85 years old or older
Total number of veterans	15,500	37,000	33,200	49,900

Source: VHA's Support Service Center data as of February 2020.

Note: Numbers in the table were rounded for reporting purposes.

The Office of Inspector General (OIG) conducted an audit on this program due to the large number of veterans enrolled; the high cost; the risks experienced by older veterans, such as loss of autonomy, poor health, and social isolation; and the volume and nature of OIG hotline complaints received.²² The objective of the audit was to determine if veterans received intended homemaker and home health aide program services, and whether VHA accurately processed program claims.

Program Administration and Oversight

The Office of Geriatrics and Extended Care (GEC) is responsible for the overall administration of the program by developing policy, monitoring program activity, and providing reports on medical facilities' compliance and performance to include the application of criteria for accessing program services. According to VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, GEC is supposed to send the deputy under secretary for health for operations and management a report twice a year that includes the percentage of program referrals that meet the criteria. GEC's chief of community care programs is currently charged with implementing these duties.

Veterans Integrated Service Network (VISN) directors are responsible for ensuring that the medical facilities within their network develop written policies, procedures, and practices for the referral, planning, and monitoring of home healthcare services. Medical facility directors are responsible for establishing written policies for maintaining the clinical and administrative processes and practices for making referrals, planning, and monitoring home healthcare services.²³ At the facility level, the organization of the homemaker and home health aide program varies. Most commonly, the program is administered at the facility level in either the social work service line or the geriatrics, extended care, and rehabilitation service line.²⁴

²² In the last five years, the OIG received 17 hotline complaints related to the program. Most of these complaints alleged unfair program eligibility, potential fraud, and delays in home health agencies getting paid on time.

²³ VHA Handbook 1140.6.

²⁴ 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.

Program Eligibility

VHA Handbook 1140.6 establishes how VHA purchases homemaker and home health aide services through home health agencies in the community. Veterans are eligible to receive program services if they are enrolled in VHA for their health care and are in need of nursing home care. VHA must offer program services to a veteran if an interdisciplinary clinical team determines that without home or community services the veteran would need nursing home care.²⁵ The clinical team uses the criteria in table 3 to identify the population of eligible veterans requesting care who are in most need of program services as an alternative to nursing home placement.

**Table 3: Criteria for Identifying Population of Veterans
in Most Need of Program Services**

Description of needs
Three or more activities of daily living dependencies, <u>Or</u>
Significant cognitive impairment, <u>Or</u>
Program services required as adjunct care to community hospice services, <u>Or</u>
Two activities of daily living dependencies <u>and</u> two or more of the following conditions: <ul style="list-style-type: none">• Has dependency in three or more instrumental activities of daily living• Has been recently discharged from a nursing facility, or has an upcoming nursing home discharge plan contingent on receipt of home and community-based care services• Is 75 years old or older• Has had high use of medical services defined as three or more hospitalizations in the past year, or has utilized outpatient clinics or emergency evaluation units twelve or more times in the past year• Has been diagnosed with clinical depression• Lives alone in the community

Source: VHA Handbook 1140.6.

Examples of daily living activities include feeding, dressing, and exercising. Because VHA Handbook 1140.6 does not define dependency in activities of daily living and instrumental activities of daily living, the audit team contacted GEC's chief of community care programs.

²⁵ According to VHA Handbook 1140.6, the phrase "in need of nursing home care" means an interdisciplinary team has made a clinical judgement that a veteran would, in the absence of home and community-based care services, need nursing home care. Veterans who meet the requirements under title 38 of the Code of Federal Regulations § 17.37 are not required to be enrolled in VHA for their health care to be eligible to receive program services.

This official reported dependency in activities of daily living is defined as when a veteran needs assistance with or cannot do an activity of daily living. This official also reported cases when veterans were unable to perform certain instrumental activities of daily living for a short time or when a caregiver needed help in maintaining the veteran's household. Examples of instrumental activities of daily living include light housekeeping, laundering, and grocery shopping.

When a veteran does not strictly meet the criteria set out in table 3, but nevertheless is determined by the clinical care team to need program services, the services may be ordered. In those instances, the reason for the variance from the standards must be documented in the veteran's record.

Once a veteran is determined to be eligible for the program, facility personnel determine the number of service hours based on the criteria. The program can be aligned under different service lines at a facility. While the program is most commonly aligned under the geriatrics, extended care, and rehabilitation service line or the social work service line, nursing or community care personnel may also make these determinations. VHA guidance recommends personnel apply the Case Mix Tool for Personal Care Services results or an alternative local medical facility tool to make this determination. Generally, the Case Mix Tool's suggested range of service hours is three to 16 hours per week. However, veterans requiring the highest level of care and at high risk of nursing home placement may need more hours of personal care services and may be eligible for up to 32 service hours per week.²⁶

Available Program Services

The program pays for a homemaker or home health aide to help veterans with their daily activities. Local home health agencies enter into agreements with the referring medical facility to provide these services for an agreed-upon fee. VHA Handbook 1140.6 states referrals for home healthcare services are made to agencies that are state-licensed or certified by the Centers for Medicare and Medicaid Services for the level of care provided. All VHA purchases of home health care will be made only from licensed and appropriately certified agencies in good standing with their state licensing bodies. In 2014, the assistant deputy under secretary for health for clinical operations issued a memorandum that noted all agencies participating in the program will have a state license to provide program services and are responsible for meeting state standards or three conditions. For example, one condition is an agency has a registered nurse on staff or has a written agreement in place for registered nurse consultation.²⁷ In addition, the agreements that these agencies enter into with facilities include standardized language describing

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

²⁷ VHA, Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services," May 23, 2014.

basic requirements, such as maintaining a license for the state, if required, where services are being provided to veterans.

Homemaker aides assist with instrumental activities of daily living, while home health aides provide hands-on help with activities of daily living. Veterans may receive program services such as light housekeeping, laundering, and preparing meals, as well as support with bathing, toileting, dressing, eating, and routine health monitoring.²⁸

Enrollment Process

The following figure details the process that veterans follow to enroll for and receive homemaker services, home health aide services, or both, from community providers.

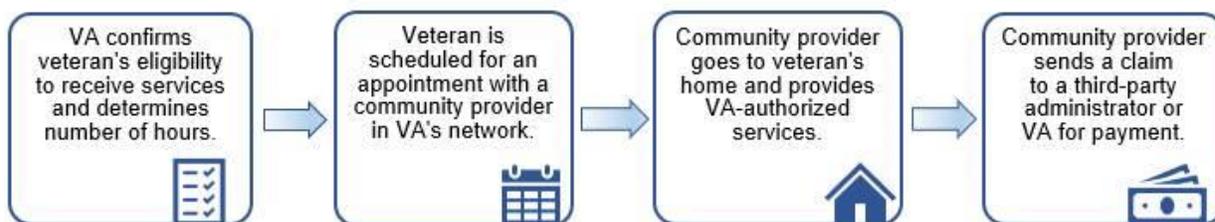


Figure 1. *OIG analysis of VA care in the community overview.*

Source: VHA Handbook 1140.6, “Case Mix Tool for Personal Care Services” memorandum, and VA community care website.

Claims Administration

VHA’s Office of Community Care (OCC) includes five directorates—Business Operations and Administration, Revenue Operations, Delivery Operations, Clinical Network Management, and Performance Improvement and Reporting. OCC personnel reported to the audit team that in April 2019 its Claims Adjudication and Reimbursement function was renamed Payment Operations and Management, which operates under the Delivery Operations directorate. OCC supports the delivery of care and services to veterans and their families through providers in the community, including through the homemaker and home health aide program. Home health agencies can submit claims for payment in person, electronically, or by mail or fax. OCC claims processors receive claims and process them through an electronic data clearinghouse. During the review period, these claims were then transmitted electronically to VA’s Fee Basis Claims System (FBCS). OCC also manages VA’s master provider database and reviews provider credentialing, certification, and accreditation.

²⁸ VHA Handbook 1140.6.

Electronic Waiting Lists

According to VHA Handbook 1140.6, medical facilities are required to use electronic waiting lists when budget resources are not sufficient to meet all identified veterans' home healthcare needs. Medical facilities are required to determine whether a veteran is eligible for homemaker and home health aide services within seven days of receiving a consult. A consult is a request for opinion, advice, or expertise from one healthcare provider to another regarding the evaluation or management of a patient's specific problem.²⁹ In 2014, the assistant deputy under secretary for health for clinical operations issued a memorandum requiring that veterans be placed on an electronic waiting list immediately once eligibility is verified and a determination is made that the service cannot be provided.³⁰ For eligible veterans who are determined to be in need of program services, the Handbook gives priority to veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rated at 50 percent or more.³¹

The OIG previously reported in its 2013 *Audit of Selected Non-Institutional Purchased Home Care Services* that medical facilities were not maintaining standardized processes to assess veterans' needs for program services and were not always using electronic waiting lists to manage veterans' demand for them.³² Electronic waiting lists should be maintained in VA's Veterans Health Information System and Technology Architecture, its electronic healthcare and administrative tracking system. Entries for veterans who are placed on electronic waiting lists for program services should be assigned the standardized numeric code of 682.³³ Veterans must be removed from electronic waiting lists once services are available and provided. During the audit review period, VHA policy required medical facilities to use these lists to track information on veterans waiting for program services. VHA announced plans in June 2020 that consults, rather than electronic waiting lists, would be used to track information on veterans waiting for program services. This change is expected to be effective by the end of 2020.³⁴

²⁹ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

³⁰ VHA, 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.

³¹ Disability compensation is a monetary benefit paid to veterans who are determined by VA to be disabled by an injury or illness that was incurred or aggravated during active military service. These disabilities are considered to be service connected. A rating percentage is a multiple of 10 percent that indicates the severity of the disability and how much it diminishes the veteran's health and ability to function.

³² VA OIG, *Audit of Selected Non-Institutional Purchased Home Care Services*, Report No. 11-00330-338, September 30, 2013. This audit examined purchased home care services, including skilled care, homemaker/home aide, respite care, and hospice services.

³³ VHA, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services."

³⁴ VHA, Assistant Under Secretary for Health for Operations Memorandum, "Simplification of New Patient Scheduling and Elimination of VHA Electronic Wait List," June 18, 2020.

Results and Recommendations

Finding 1: VHA Lacks Assurance That Veterans Received Intended Homemaker and Home Health Aide Program Services

VHA cannot be certain that veterans received intended homemaker and home health aide program services. Based on an analysis of a random sample of 200 program claims, the audit team estimated almost half of the 1.1 million claims that VHA paid to home health agencies were made to agencies for which VHA had no assurance of licensure, certification, or exemption/local approval when required from September 2018 through February 2019.³⁵ VHA cannot be certain that veterans received program services from home health agencies that, when necessary, were in good standing with state licensing and certifying agencies during this six-month period. Of the 100 medical facilities with program policies or practices, the team identified 22 facilities using additional requirements not specified in VHA guidance, including VHA Handbook 1140.6, that may unintentionally have resulted in inconsistent access to services for some veterans across facilities.³⁶

The team could not conclusively identify the total number of medical facilities where veterans were waiting on an electronic waiting list specifically for homemaker and home health aide services. In addition, the team found differences in how some facility personnel addressed veterans who were difficult to place because of inappropriate behavior towards homemaker or home health aides. Medical facilities must verify veterans' suitability for program services and determine whether services can be provided within seven days of a consult.³⁷ Some facilities did not make this determination within seven days. GEC's chief of community care programs also reported VHA stopped monitoring some program activity because VISN and medical center facility personnel complained that the process was administratively burdensome. Without this information, VHA cannot be fully aware of the number of veterans who are potentially eligible for program services and manage resources to meet veteran demand.

³⁵ This estimate is based on 103 randomly selected program claims submitted by home health agencies without valid licenses or certifications identified in the team's sample. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit.

³⁶ Forty-one program personnel from 141 facilities reported through the OIG audit team's survey that they did not have a local program policy, used VHA Handbook 1140.6 rather than a local policy, or used a combination of national policy and OCC guidance to operate their programs. The team could not confirm whether veterans at facilities without written local policies were provided access to program services consistent with facilities that had written policies, as required.

³⁷ VHA, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services."

What the OIG Did

The audit team interviewed GEC officials, OCC officials, and medical facility personnel who were responsible for overseeing the homemaker and home health aide program. In addition, the team analyzed survey responses provided by 18 VISN and 121 medical facility program contacts to determine how VISNs and facilities developed local policies, monitored services to veterans, and used electronic waiting lists. Program contacts included VISN and medical facility personnel with responsibilities for the day-to-day management and/or operations of the program. The team reviewed the licenses or certifications for 177 home health agencies that provided program services to veterans from September 2018 through February 2019.³⁸ These home health agencies were identified in the team's review of 200 randomly sampled claims OCC approved for payment during this time frame.³⁹ In addition, the team collected and analyzed information from VHA Support Service Center electronic waiting list reports. The team also used consult data reported by 41 facilities to calculate how long these facilities took to consider veterans for program services. The team considered local policies and practices for 100 medical facilities to identify how these facilities provided veterans access to intended services. Appendix B provides additional details on the audit scope and methodology. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit.

VHA Lacks Assurance That Veterans Received Services from Licensed or Certified Home Health Agencies When Required

VHA Handbook 1140.6 states all VHA purchases of home health care will be made only from licensed and appropriately certified home health agencies in good standing with state licensing bodies. The Handbook does not provide details on what medical facilities should do when agencies do not meet these requirements. In 2014, VHA issued a memorandum stating that all agencies participating in the homemaker and home health aide program will (1) have a state license to provide program services and are responsible to meet state standards, or (2) meet certain conditions outlined in the memorandum, such as having a registered nurse on staff or a written agreement in place for a registered nurse consultation.⁴⁰ VHA Handbook 1140.6 states that on the recommendation of a VISN director, GEC may approve exemptions on the cost of

³⁸ This review period, which covered the six months prior to the start of the audit in March 2019, was selected to ensure the audit team's findings and recommendations were based on current data.

³⁹ The audit sample size of 200 claims 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 (for example, ensuring the timeliness of presenting review findings). While precision improves with larger samples, the rate of improvement decreases as more records are added to the sample review. The sample size was selected for strata error rates ranging from 10 to 50 percent at a 90 percent confidence level. The overall margin of error for error rate projections from this sample size was calculated to be between 5 and 8 percent.

⁴⁰ VHA, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services."

maximum care, license, or accreditation of agencies. While this was reaffirmed in the 2014 memorandum, the Handbook has not been updated to reflect the memorandum's guidance.

From September 2018 through February 2019, VHA paid an estimated 546,000 claims (49 percent) to about 3,300 home health agencies that were unlicensed and uncertified.⁴¹ As a result, VHA may have made up to an estimated \$145.4 million in improper payments.⁴² In addition, the audit team considered these payments improper, but not recoverable. This estimate is based on 103 randomly selected program claims submitted by home health agencies without valid licenses or certifications identified in the team's sample. This estimate includes agencies in the 42 states and Washington, DC, that were required to be licensed during the review period. The review included agencies that served veterans in Puerto Rico because the territory had local health requirements for agencies providing program services to veterans. This estimate excludes agencies in the eight states where licenses were not required during the review period.⁴³

The audit team considered a home health agency to be unlicensed or uncertified if (1) evidence of licensure or certification was not available in VA's two online repositories, (2) OCC or medical facility personnel did not provide documentation of a license or certification, or (3) an agency's license or certification was expired during the dates of service for the claims in the review period. GEC's chief of community care programs reported there were no license or accreditation exemptions during the audit timeframe. This official referred the team to OCC regarding how information on agencies' licenses and certifications is tracked. The team determined that the online repositories that VHA used to track licenses and certifications did not capture whether agencies met the three conditions outlined in the 2014 memorandum.⁴⁴ Some medical facilities may have either exempted or locally approved agencies that met the conditions in the 2014 memorandum, but did not report this information to GEC or a VISN director as required by VHA guidance.

VHA has previously experienced deficiencies in the oversight of home health agencies. In 2013, the OIG reported in the *Audit of Selected Non-Institutional Purchased Home Care Services* that 31 of 200 agencies reviewed lacked required state licenses and/or the Centers for Medicare and

⁴¹ The audit team determined there were about 6,600 unique home health agencies that submitted program claims during the review period.

⁴² Office of Management and Budget, Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. This circular defines an improper payment as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Appendix B provides additional details on the improper payments made to home health agencies without valid licenses or certifications during the review period. Appendix E details the potential monetary benefits that the team identified.

⁴³ The eight states that did not require agencies to be licensed during the review period were Alabama, Iowa, Massachusetts, Michigan, Ohio, South Dakota, Vermont, and West Virginia.

⁴⁴ VHA, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services."

Medicaid Services certifications. These agencies provided over 1,100 veterans with \$5 million in homemaker and home aide, respite, and skilled care services. The OIG recommended the under secretary for health implement management controls to ensure VA medical facilities adhere to VHA's requirements related to the identification and management of ineligible and high-risk purchased home care agencies.⁴⁵

In response to the OIG's 2013 report, VHA provided guidance and training to medical facility staff on quality oversight and monitoring. However, during the audit review period, most medical facility directors were not meeting the requirement to verify in annual reports that agencies are in good standing with state licensing and certifying agencies.⁴⁶ According to the audit team's May 2019 survey of facility contacts responsible for the day-to-day management of the program, only about 35 percent of respondents reported providing their medical facility directors with quality management reports. In addition, officials from OCC—the office charged with processing homemaker and home health aide claims for payment—told the team that they were aware that facility program personnel were not consistently validating home health agencies' licenses or certifications. Facility directors are ultimately responsible for ensuring agencies providing program services meet applicable quality standards. Facilities' use of unlicensed or uncertified agencies puts veterans at risk of receiving care that does not meet program standards.

In May and August 2019, OCC established interim procedures aimed at improving oversight of the licenses and certifications of home health agencies applying to provide veterans with program services. This process addressed states that do not require agencies to have a healthcare license, noting that agencies must have a formal relationship with VA or an agency in the state. These relationships can include a contract or provider agreement with VA or an approval certification from a state aging unit.⁴⁷ Because these procedures were not fully implemented during the review period, the audit team was unable to evaluate to what extent these procedures may reduce the number of unlicensed and uncertified home health agencies providing program services to veterans.

Some Facilities Applied Program Policies and Practices Differently

VHA Handbook 1140.6 directs how VHA purchases homemaker and home health aide services through home health agencies in the community. Veterans are eligible to receive program services if they are enrolled in VHA for their health care and are “in need of nursing home

⁴⁵ VA OIG, *Audit of Selected Non-Institutional Purchased Home Care Services*.

⁴⁶ VHA Handbook 1140.6.

⁴⁷ VHA OCC, “Utilizing Interim Certification Solution in Place of Credentialing Standard Operating Procedure,” May 2019; and VHA OCC, “Interim Credentialing Committee Quality Control Standard Operating Procedure,” July 2019.

care.”⁴⁸ This guidance reflects the Veterans’ Health Care Eligibility Reform Act of 1996, which extended eligibility for these services to disabled veterans who do not have a service-connected disability.⁴⁹ As mentioned earlier, the phrase “in need of nursing home care” means an interdisciplinary clinical team has determined that the veteran would, in the absence of home health care, need nursing home care. The Handbook lists criteria to identify veterans who need home health services as an alternative to nursing home care. As table 3 indicated, the list of criteria includes the need for assistance in performing various daily living activities, significant cognitive impairment, and other combinations of factors, such as frequent hospitalizations, age, living alone, hospice support, and clinical considerations. Recognizing the policy could not foresee every contingency, the Handbook noted a clinical care team could order home health services for veterans when they needed the care despite failing to meet the specified criteria. This deviation should be documented in the veteran’s medical record.

VHA Handbook 1140.6 notes medical facility directors are required to establish a written facility policy for maintaining the clinical and administrative processes and practices for referral, planning, and monitoring of program services. Of 100 medical facilities with local policies or practices, the audit team identified 22 facilities that applied additional considerations other than those included in the Handbook and the Case Mix Tool for Personal Care Services.⁵⁰ Table 4 summarizes the team’s findings.

Table 4. Local Program Policies and Practices with Additional Considerations for Providing Services

Review findings	Local policies or practices	Number of facilities
Included additional program criteria (such as age and behavior history)	Policies	9
Prioritized some veterans for program services	Policies	6
Offered fewer program service hours	Practices	4
Prioritized access to program services and offered fewer service hours	Policies and practices	3

Source: VA OIG analysis of 22 medical facilities’ policies and practices.

- Nine of the 22 facilities have local policies with criteria not specified in VHA Handbook 1140.6 for determining veterans’ access to program services. Veterans using these nine

⁴⁸ Veterans who meet the requirements under title 38 of the Code of Federal Regulations § 17.37 are not required to be enrolled in VHA for their health care to be eligible to receive program services.

⁴⁹ Veterans’ Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262 (1996).

⁵⁰ Forty-one program staff at various facilities reported to the audit team that they did not have a local program policy, used the Handbook rather than a local policy, or used a combination of national policy and OCC guidance to operate their programs. The team could not confirm whether veterans at facilities without written local policies were provided access to program services consistent with facilities that had written policies.

facilities with distinct local policies may be subject to, or prioritized based on, program criteria in addition to those in the Handbook. These nine local policies were related to the veteran's age, health, the results of additional clinical assessments, or the presence of specific health conditions.

Example: The John D. Dingell VA Medical Center in Detroit, Michigan, required an eligibility review that included an additional assessment completed by a social worker within the prior six months describing the veteran's current living situation and a justification for program services.

- Six of the 22 facilities with local policies applied criteria not referenced in VHA Handbook 1140.6 for prioritizing veterans' access to program services, resulting in some veterans receiving access to home health services before similarly situated veterans in other VA health systems. Title 38 of the United States Code § 1720C(a), which is incorporated in the Handbook by reference, requires medical facilities to give priority to veterans who are in receipt of, or in need of, nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rating of 50 percent or more. If veterans are found eligible to access homemaker and home health aide program services and VHA is unable to provide those services due to insufficient budget, the Handbook requires that those veterans be placed on an electronic waiting list.

Example: The Beckley VA Medical Center in West Virginia reported using criteria that prioritized veterans with a service-connected disability rating of 70 percent or more as opposed to 50 percent or more.

- Four of the 22 facilities established local practices that appeared inconsistent with the number of program service hours offered to enrolled veterans at other facilities. These facilities offered fewer hours than the Case Mix Tool for Personal Care Services indicated. VHA guidance recommends that medical facilities provide hours of care that align with the Case Mix Tool or an alternative local medical facility tool to certify a veteran's need for services. A clinician can use the Case Mix Tool to help identify the number of service hours for a veteran. The Case Mix Tool groups service hours from as few as three to six hours to as many as 14 to 16 hours.⁵¹

Example: Medical facility personnel at the Amarillo VA Health Care System in Texas reported that there was no written policy that limited the number of service hours veterans could receive. However, it is the system's practice that veterans typically do not receive more than four hours of care per week. Therefore, veterans needing more than four hours of care may not always receive it.

⁵¹ VHA, "Case Mix Tool for Personal Care Services."

Program personnel at the Amarillo VA Health Care System reported the system's limit on hours was established due to budget constraints. While some variation in capacity is expected among different VA healthcare systems, local facilities' circumstances may limit how many program service hours are provided to veterans based on where they live.

- Three of the 22 facilities had additional prioritization practices based on service-connected disability ratings and potentially offered fewer service hours due to factors such as processing or budget limitations.

Example: VA's Eastern Kansas Health Care System's local program policy requires that veterans who need more than eight hours of services per week receive additional approval from the GEC service line manager before services are authorized. An individual involved with the program reported the facility tries to limit the number of hours provided to veterans because of budget concerns.

During audit team interviews, some facility personnel reported their local policies and procedures were developed in response to local circumstances such as budget limitations. These policies and practices, while not explicitly prohibited, may result in inconsistent access to program services and service hours across VHA facilities nationwide. Medical facilities' electronic waiting lists should show how many veterans are waiting for program services. However, if veterans were prioritized differently because of these additional requirements, those not meeting the additional criteria may not be placed on these lists and comparisons among lists may be unreliable. As an unintended consequence, the actual veteran demand for program services at these facilities may be underrepresented to VA.

GEC Chief Concerned That Some Facilities Unintentionally Provided Inconsistent Access to Program Services

The GEC chief of community care programs, responsible for the homemaker and home health aide program, acknowledged that VHA medical facilities are allowed some flexibility locally because VHA Handbook 1140.6 does not cover all areas involved in operating the program. In this official's opinion, however, facilities should not have local policies or practices that result in all veterans receiving the same number of service hours. The audit team determined program guidance does not address medical facilities' capacity concerns. VHA should consider revisiting its program resources and guidance to provide more consistent access for all eligible veterans that is responsive to their varying levels of need.

In addition, the GEC chief of community care programs reported VHA had not recently collected data on program agency quality or veterans' outcomes. At one time, VHA had a compliance report that captured the percentage of veterans who met the clinical target population for program services. This official reported VHA discontinued the report at least 14 years ago at the

request of VISN and medical facility personnel because it was administratively burdensome. This data would provide the deputy under secretary for health for operations and management with some of the program information needed to identify medical facilities where veterans may not be receiving program services as intended.

VHA reported to the audit team that it is planning to take actions to address this information gap. According to GEC's associate executive director, beginning in FY 2021, the Case Mix Tool results will be included as part of a veteran's electronic healthcare record. This data will be aggregated by medical facility and allow VHA to determine, on a national basis, veterans' personal service needs and the extent to which facilities are reaching the program's target population. In addition, VHA will be able to match, by facility, Case Mix Tool results to referral data to determine how closely results match the amount of care ordered. Without an understanding of the challenges that facilities are facing when implementing the program, GEC is not positioned to develop alternatives or address the causes for differences in eligible veterans' access to program services and allowable hours.

VHA Is Unable to Track Veterans Waiting for Services Nationally

Another critical information source for VHA leaders is each facility's waiting lists. Medical facility directors are responsible for ensuring electronic waiting lists are used to track veterans waiting for homemaker and home health aide services.⁵² However, the audit team could not conclusively identify the total number of medical facilities where veterans were waiting on an electronic waiting list specifically for homemaker and home health aide services. VHA does not have a unique numeric code to specifically track veterans waiting for homemaker and home health aide services; VHA uses code 682 to track services available through several programs. Due to VHA's use of one code for several programs, GEC's chief of community care programs cannot effectively monitor medical facilities' capacity to meet veteran demand for particular program services. Nationally, VHA is unable to determine veteran demand for homemaker and home health aide services. Without this information, VHA cannot assess whether additional resources are needed to support program operations.

Some Facilities Prioritized Veterans on Electronic Waiting Lists for Program Services Differently

Once veterans are placed on an electronic waiting list, medical facilities are supposed to provide program services as budget resources become available. In these cases, by statute and in accordance with VHA Handbook 1140.6, facilities should provide services first to veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a

⁵² VHA Handbook 1140.6.

service-connected disability, or who have a service-connected disability rating of 50 percent or more.⁵³

While VHA Handbook 1140.6 addresses electronic waiting list prioritization when there is a lack of budget resources, it does not reflect what facilities should do when home health agencies in the community cannot meet facilities' demand for homemaker and home health aide services. In 2014, VHA issued a memorandum requiring the use of electronic waiting lists anytime home health services cannot be immediately arranged.⁵⁴ However, the Handbook has not been updated to reflect the memorandum's guidance addressing how facilities should prioritize veterans on waiting lists for nonbudgetary reasons. This might include, for example, when care providers lack the number of staff with qualifications that are responsive to particular veterans' needs. Taken together, the Handbook and memorandum guidance are somewhat unclear about whether both budgetary and nonbudgetary limitations affecting services should be reflected on the waiting list, which would appear to be the case. Moreover, there is lack of clarity regarding how to reflect in a waiting list whether a veteran is receiving fewer hours than allowed until or unless additional resources are made available to fully meet service needs, or how to address a lack of provider capacity in the community to support the program.

In response to the audit team's May 2019 survey, facilities stated that they often placed veterans on electronic waiting lists due to (1) a lack of homemaker and home health aide staff, (2) a limited number of home health agencies near veterans' homes, and (3) an increase in the number of veterans enrolled in the program. Based on survey responses, the team determined that veterans were either not prioritized or prioritized in different ways at the 20 medical facilities with veterans on their electronic waiting lists. Of the facilities that reported using electronic waiting lists, their approaches to prioritization were as follows:

- Two facilities with electronic waiting lists for program services reported considering only service-connected disability ratings when prioritizing veterans on those lists. These actions are in compliance with title 38 of the United States Code, § 1720C, which is incorporated in VHA Handbook 1140.6 by reference.
- Three facilities reported not prioritizing veterans on electronic waiting lists. This is not in compliance with the statute and the Handbook.
- Six facilities reported considering only factors not referenced in the Handbook when prioritizing veterans. The Handbook does not prohibit the consideration of other factors; however, these facilities did not consider service-connected disability ratings as required by the statute and the Handbook.

⁵³ Title 38 United States Code § 1720C(a).

⁵⁴ VHA, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services."

- Nine facilities reported that a veteran’s service-connected rating was considered in combination with other factors not referenced in, but not prohibited by, the Handbook when prioritizing veterans on waiting lists.

Whereas table 4 reflects whether veterans met additional criteria to *access* services, table 5 details the factors that facilities reported using when *prioritizing* which veterans waiting for services should be referred to home health agencies as resources became available.

Table 5: Factors Facilities Reported Considering When Prioritizing Veterans on Electronic Waiting Lists

Factor	Frequency facilities reported considering each factor
Veteran’s clinical need for program services	12
Service-connected disability rating	11
How long the veteran had been on the list	9
Additional factors (such as home health agencies’ availability)	7
Veteran’s age	3

Source: VA OIG analysis of responses to the audit team’s national survey of program personnel.

Note: Some of the 20 facilities reported considering more than one factor.

Facility personnel addressed veterans waiting for services as local program capacity allowed.

Examples: Program personnel from the VA Puget Sound Health Care System in Seattle and Tacoma, Washington, informed the audit team that 639 veterans were on the facility’s electronic waiting list at the time of the team’s survey because of a lack of program funding and an increase in veteran enrollment. To address this situation, veterans were prioritized based on factors such as the order in which they were placed on the list and their clinical need for program services.

In another case at the time of the survey, the Albany Stratton VA Medical Center in New York reported 87 veterans were on an electronic waiting list for program services. Program personnel from this facility reported that they sent the names of waiting veterans to local agencies each month. Personnel stated that they sent out the list in this manner in the hope that agencies would have the capacity to serve at least some of the waiting veterans.

Increases in veteran demand and the lack of staffing, budget, and community resources can delay or prevent services from being provided to veterans. The result is that some VHA medical facilities are prioritizing veterans on waiting lists differently from others across the country. In

addition, VHA cannot identify the number of medical facilities where veterans' needs for program services are unmet or are only partially addressed. Without a consistent process to track and consider how facilities are managing their waiting lists, VHA does not have the information necessary to ensure that veterans are receiving program services as originally intended.

Insufficient Guidance Affects How Medical Facilities Handle Hard-to-Place Veterans in Need of Program Services

VHA Handbook 1140.6 does not provide guidance on steps facilities should take when home health agencies will not serve veterans in the program because of the patient's prior disruptive or abusive behavior. Some medical facilities placed veterans who reportedly acted inappropriately or were abusive to home health aides in prior encounters on electronic waiting lists.

The audit team contacted program officials from eight medical facilities with a homemaker and home health aide program and determined that some facility personnel addressed veterans who were difficult to place differently. For example, Syracuse and the Albany Stratton VA Medical Centers in New York had veterans on their waiting lists with histories of inappropriate or abusive behavior who could not be placed with a home health agency. Program personnel from the Albany Stratton VA Medical Center described their local practice of attempting three times to place a hard-to-place veteran with different agencies before removing the veteran from the program and the facility's waiting list. Similarly, a nurse manager involved with the program from the VA Greater Los Angeles Healthcare System in California reported that if a veteran had behavioral issues, program staff first tried to work with the veteran and agency to find a resolution. If a veteran's conduct persisted, then the veteran was removed from the program and not placed on an electronic waiting list.

VHA Handbook 1140.6 does not require facilities to inform veterans who are removed from the program of their appeal rights.⁵⁵ In addition, in the absence of a clearly defined policy on steps facilities should take when veterans cannot be placed with home health agencies because of their past or current behavior, it is unclear when facilities are permitted to remove veterans from program placement consideration.

Some Medical Facilities Exceeded Timeliness Requirement for Determining Veterans' Suitability for Program Services

Medical facilities must verify veterans' suitability for program services and determine whether services can be provided within seven days of a consult.⁵⁶ Some facilities did not make this determination within seven days. To determine whether facilities verified veterans' suitability for

⁵⁵ VHA Directive 1041, *Appeal of VHA Clinical Decisions*, October 24, 2016, details the process for appealing clinical decisions.

⁵⁶ VHA, "Additional Guidance on Use of the Electronic Wait List for Geriatrics & Extended Care Services."

homemaker and home health aide services within seven days of a consult, the audit team collected program consult data in August 2019 from 41 facilities that did not maintain electronic waiting lists for the program. Of these, 38 had not determined veterans' suitability within seven days for nearly 2,500 active and pending consults. Facility programs maintain consults in a pending and an active status before they are scheduled for services.⁵⁷ Facilities did not comply with policy, as personnel did not make the determination if these veterans should be placed on an electronic waiting list for the program within seven days of the consult request date.

Some circumstances may affect how quickly a program consult is processed.

Example: The VA North Texas Health Care System in Dallas and Bonham had the most pending and the second-most active consults older than seven days at the time of this audit—approximately 100 and 300, respectively. The community home care assistant nurse manager at this facility reported that the facility's executive leaders decided not to create an electronic waiting list for the program because they determined it was not in the veterans' best interest and there were adequate resources in the community to care for these veterans. This manager also attributed the delays in processing these program consults to the additional administrative requirements resulting from the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018).

However, GEC's chief of community care programs stated that medical facilities that are unable to make timely program referrals should place veterans on an electronic waiting list. It was this official's opinion that there is a risk that veterans will not receive the intended services. Program managers and facility leaders cannot accurately account for the number of veterans who are waiting for program services when facilities fail to consider consults on time. When facilities are delayed in considering program consults, these consults can become unofficial waiting lists.

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 cannot be scheduled for an appointment or who choose to wait for a VHA provider instead of a community provider. Effective December 1, 2020, the plan eliminates electronic waiting lists and allows facilities to keep consults active for 390 days.⁵⁸ It is unclear if this change will improve VHA's information on veterans' unmet needs for program services. If the plan does not provide guidance on what to

⁵⁷ VHA Directive 1232(2), *Consult Processes and Procedures*, notes that pending status designates requests that have been sent but have not yet been acted on by the receiving service. Active status occurs when a consult is received and efforts are underway to fulfill it. A consult may also revert to active status in other scenarios, such as when an appointment is canceled or a veteran does not show for his or her appointment.

⁵⁸ VHA, "Simplification of New Patient Scheduling and Elimination of VHA Electronic Wait List."

do when consults for program services cannot be closed within 390 days, veterans' needs may not be addressed.

Finding 1 Conclusion

In FY 2019, of the approximately 136,000 veterans in the homemaker and home health aide program, more than a third were 85 years old or older. Many older veterans are frail, have multiple health concerns, live alone, or are isolated from their communities. The program was intended to provide these vulnerable veterans with the support to allow them to remain in their homes as long as possible. However, the program continues to be affected by the same oversight vulnerabilities identified by the OIG in the *Audit of Selected Non-Institutional Purchased Home Care Services* report in 2013.⁵⁹

Veterans are eligible to receive program services if they are enrolled in VHA for their health care and need nursing home care. Due to local policies and practices, some veterans may experience different access, longer wait times, and fewer program services than veterans in other VA health systems. This may be due, in part, to the distinct capacities and capabilities of home health agencies that provide program services, and facilities prioritizing veterans on program waiting lists using different criteria or using the consult process in lieu of waiting lists. VHA's GEC does not have the reports needed to ensure medical facilities are meeting all eligible veterans' needs for services and providing consistent and timely access to quality program services across facilities. Until steps are taken to address these persistent problems and ensure appropriate program oversight, VHA will remain unable to achieve its goals in serving the growing population of vulnerable veterans living in their homes.

Recommendations 1–5

The OIG recommended the under secretary for health take the following actions:⁶⁰

1. Assess whether current program policies and practices meet the needs of medical facilities' local homemaker and home health aide programs and update them as necessary.
2. Update homemaker and home health aide program guidance to include processes that medical facilities must follow when assessing whether home health agencies are licensed or certified, meet specified conditions, or will be exempted from program requirements, to include determining a mechanism to track data on these decisions locally and nationally.

⁵⁹ Appendix A provides additional details about prior related reports and the status of recommendations.

⁶⁰ Recommendations directed to the under secretary for health were submitted to the executive in charge who has the authority to perform the functions and duties of the under secretary.

3. Update homemaker and home health aide program guidance to include procedures that medical facilities must follow to determine the suitability of veterans for program services when they cannot meet veterans' program needs within the required period of time because of facility or community resource constraints.
4. Implement procedures for medical facility directors to use data on veteran demand, including unmet demand, for homemaker and home health aide program services to manage their local program resources.
5. Update homemaker and home health aide program guidance to include processes that medical facilities must complete when veterans with care needs have been refused services from home health agencies because of demonstrated behavioral issues.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with Recommendations 1 through 5 of the report. He considered the actions taken for Recommendation 2 complete and asked the OIG to consider closing this recommendation.

The executive in charge recognized that guidance on the homemaker and home health aide program had not been published since 2014. He reported GEC will publish updated guidance on the homemaker and home health aide program as a subsection in the OCC Field Guidebook specialty programs chapter to address Recommendations 1, 3, and 5.

To address Recommendation 2, the executive in charge reported GEC published guidance detailing the standards for long-term services purchased from community providers, including homemaker and home health aide providers, in the OCC Field Guidebook on July 23, 2020. This guidebook includes criteria to use when credentialing homemaker and home health aide providers. In addition, according to the contracts between the third-party administrators and VHA, homemaker and home health aide providers in the community care network are credentialed by a third-party administrator. According to standard operating procedures most recently updated on June 5, 2020, homemaker and home health aide providers with agreements with VHA are also credentialed by an OCC review team. The credentialing process is documented in accordance with the OCC Provider Profile Management System User Functionality standard operating procedures.

In addition to updating the OCC Field Guidebook in response to Recommendation 3, GEC will refer medical facilities to national direction from the assistant under secretary for health for operations (memorandum titled "Simplification of New Patient Scheduling and Elimination of the VHA Electronic Wait List") and any subsequent policy guidance from VHA's Office of Veterans Access to Care when they cannot meet veterans' program needs within the required period of time because of facility or community resource constraints. GEC needs more information on the reports of open consults that are expected to replace electronic waiting lists to

make sure medical facilities are aware of the status of their homemaker and home health aide programs. GEC will formulate a specific action plan, if required, once VHA policy on this topic is issued.

To address Recommendation 4, the executive in charge reported GEC also needs more information on the reports of open consults that are expected to replace electronic waiting lists to make sure medical facilities are aware of the status of their homemaker and home health aide programs. GEC will formulate a specific action plan, if required, once VHA policy on this topic is issued.

OIG Response

The executive in charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG reviewed the executive in charge's response to Recommendation 2 and the supporting documentation submitted and considers the recommendation closed. The OIG will monitor implementation of the additional planned actions and will close the other recommendations when VHA provides enough evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix D includes the full text of the executive in charge's comments.

Finding 2: VHA Paid More Than Half of Program Claims within 30 Days and Nearly Always Accurately, but Opportunities Exist for Improvements

VHA generally paid claims for homemaker and home health aide services within 30 days and almost always accurately. However, OCC can take steps to reduce its risk of making improper payments. OCC made improper payments when the payments should not have been made or were made in an incorrect amount under applicable legal requirements.⁶¹ Improper payments may include overpayments or underpayments. In addition, when an agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, the payment should also be considered an improper payment.

The audit team estimated that VHA improperly paid at least \$8.5 million to home health agencies, with at least \$5.5 million of this amount potentially recoverable if VHA decides it would be appropriate to take action. The team's improper payment estimates are based on 19 claims that the team found were deficient from a sample of 200 randomly selected program claims. Deficiencies included errors in the number of service hours authorized and claimed, payments made more than once (duplicate payments), and claims with overpayments.⁶² Due to the variability of this projection and the small sample size, the audit team conservatively reported the lowest level of the confidence interval to demonstrate to VA the potential risk to VHA resources. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit. Appendix E provides more details on the potential monetary benefits.

What the OIG Did

The audit team reviewed a random sample of 200 claims. These claims were sampled from 1.1 million approved claims that represent about \$331.1 million in payments made from September 2018 through February 2019. The value of the 200 approved claims totaled about \$53,300. The sample size used for this audit was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and the audit timeline. While precision improves with larger samples, the rate of improvement decreases as the sample size increases. The sample size was selected for strata error rates ranging from 10 to 50 percent at a 90 percent confidence level. The overall margin of error for error rate projections from this sample size was calculated to be between 5 and 8 percent.

⁶¹ Office of Management and Budget, Circular A-123.

⁶² In the case of four of the 19 claims, the OIG audit team determined that payments were improper, but could not be recovered due to a lack of documentation.

The results of the team's review reflect individual counts of deficiencies, and an approved claim could have multiple deficiencies. For example, an approved claim could have been paid late and for the wrong amount. The team reviewed authorizing and payment processing claim forms and information from VA's FBCS to determine if these claims were processed and paid on time and correctly. FBCS is an auditing system that was designed to track, report, and analyze fee claim data. The team shared and discussed the results of the program claims review with OCC personnel, then updated the analysis as appropriate. In addition, to test for fraud, the team reviewed timesheets from home health agencies to verify that agencies submitted claims that matched the authorization documentation. Furthermore, the team interviewed OCC officials and program personnel to gain an understanding of claims processing and quality assurance procedures. Appendix B provides additional details on the audit scope and methodology.

More Than Half of Program Claims Were Paid within 30 Days

The VA MISSION Act of 2018 includes a prompt payment standard that electronic claims are paid within 30 calendar days upon receipt of claim.⁶³ The team considered all program claims reviewed to be electronic, as this analysis was based on the date that program claims were added to FBCS.

As discussed earlier, from September 2018 through February 2019, VHA paid an estimated 598,000 claims (or about 54 percent) within 30 days of being submitted by a home health agency. Figure 2 illustrates how long it took VHA to pay these claims.

⁶³ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, Pub. L. No. 115-182, § 111 (2018).

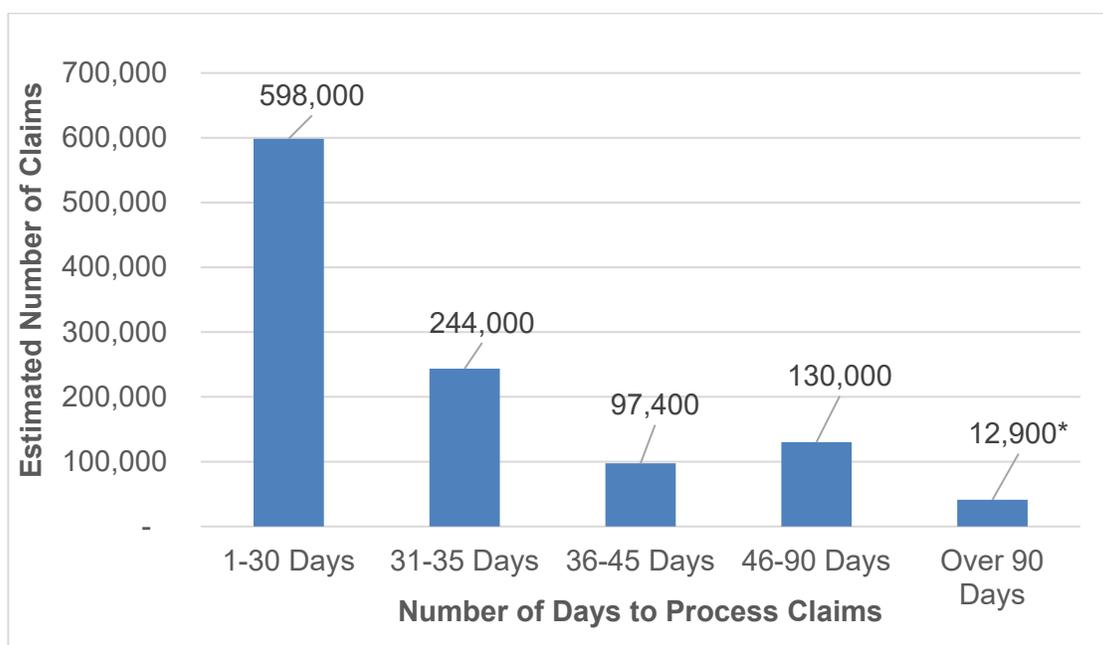


Figure 2. VHA’s timeliness of paying program claims.

Source: VA OIG analysis based on 200 randomly sampled homemaker and home health aide program claims approved from September 1, 2018, through February 28, 2019.

Note: For reporting purposes, some numbers in figure 2 are rounded and the intervals for number of days to process claims are not all equal.

*The audit team reported the lower level of the confidence interval for this projection because of its variability.

While VHA was successful in paying claims for more than half of the claims under the audit team’s analysis in a timely manner, opportunities exist for OCC to improve its claims payment process. It still took OCC longer than 30 days to process the remaining estimated 512,000 claims (or about 46 percent) for payment during this six-month period. These claims were not processed within 30 days in part because FBCS—the system that OCC used to process claims—does not alert claims processors and other users to older claims. Developing a mechanism to alert OCC personnel to older claims, for example through routine reporting or a system-generated notification, would better position VHA to pay home health agencies more quickly. Home health agency representatives interviewed by the team reported concerns regarding their ability to continue to do business with VHA when it does not promptly pay them for services they provided to veterans.

VHA Guidance Is Inconsistent with Federal Standards on Agencies’ Documentation for Justifying Their Service Charges for Payment

VHA guidance on what documentation agencies are required to submit for payment is inconsistent with federal standards. While VHA program guidance does not require facilities to collect documentation to support payments, the Government Accountability Office’s federal

standards for internal controls recommend that all transactions be clearly documented and readily available for examination.⁶⁴ In addition, when an agency is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.⁶⁵ Because VHA did not require facilities to collect documentation, the audit team could not always verify details about the program services rendered.

The audit team found that OCC processed claims without documentation to adequately support the number of hours of services that home health agencies claimed they provided to veterans. At the time of the audit, VHA did not require home health agencies to submit timesheets or other documentation to support their claims. As part of the audit, the team requested timesheets from agencies. Based on the results of a review of the timesheets received, an estimated 197,000 (or about 18 percent) of the program claims that OCC processed and approved for payment between September 2018 and February 2019 did not have adequate support to justify the number of hours that home health agencies charged. This estimate is based on 34 of 200 randomly selected program claims that the team determined were deficient. VHA could not provide timesheets for 27 of these claims. For the remaining seven claims, the timesheets did not match the claimed amounts. VHA overpaid three of these claims, as the number of hours claimed were greater than the agencies' submitted documentation. For the remaining four claims, the timesheets did not include start and stop times or were inconsistent with the claimed amounts. Without documentation to support claims, OCC does not have a control to ensure that veterans received claimed services from home health agencies. The following example details an instance when home health aides' timesheets did not support the number of hours billed by the home health agency, but OCC still paid the claim.

Example: A veteran was authorized by a VHA medical facility to receive program services from October 2017 through September 2018.⁶⁶ In August 2018, a home health agency submitted a claim for services provided to the veteran. However, the timesheets provided by the home health agency noted that the home health aide did not provide services on the specified day in August. The veteran's daughter refused services that day because the aide was late.

⁶⁴ VHA Handbook 1140.6; VHA OCC "VA Community Care Standard Operating Procedure," June 2018; and Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-70G, September 2014.

⁶⁵ Office of Management and Budget, Circular A-123.

⁶⁶ The audit team did not include the names of the VHA medical facilities referenced in this finding for patient privacy reasons.

OCC officials agreed that a process needs to be developed to address the risks associated with processing timesheets. Without sufficient supporting documentation, VHA faces increased risk of fraud and is unable to determine whether veterans received authorized program services.

Medical Facility Personnel Sometimes Did Not Establish Authorizations Prior to Agencies Providing Program Services

OCC is responsible for processing homemaker and home health aide claims for payment. Personnel at VHA medical facilities create payment authorizations for eligible veterans to obtain care from non-VA healthcare providers. Then, finance personnel are required to record the activity in FBCS. According to the FBCS Administrator Manual, when an authorization is created after the service or treatment was provided to the veteran, a delinquent obligation occurs. VA financial policy defines a delinquent obligation as an obligation that has been properly authorized to procure services, supplies, or equipment, but finance personnel have not recorded the activity in the accounting system of record.⁶⁷ From September 2018 through February 2019, VHA had an estimated 150,000 delinquent obligations representing about 14 percent of claims.

FBCS does not have a control function to stop authorized services from being provided to veterans when the payments are not authorized in the system as required. Due to this lack of control, OCC may be late in paying home health agencies. The following examples are delinquent obligations created when medical facility personnel established the authorizations in FBCS after agencies provided services to veterans.

Examples: A veteran was authorized by a VHA medical facility to receive program services from June through September 2018. The home health agency provided those services to the veteran in June 2018. VHA medical facility personnel entered the authorization for service in FBCS in July 2018—more than two weeks after the veteran received the services.

A VHA medical facility authorized a veteran to receive program services from October 2018 through June 2019. The home health agency provided services to the veteran in November 2018. VHA medical facility personnel entered the authorization for service in FBCS on January 2019—about two months after the veteran received services.

VHA lacked claims processing controls in FBCS that ensured program authorizations for services are entered in the system prior to those services being provided to veterans. OCC officials reported that claims processors focused on processing claims in FBCS, regardless of the

⁶⁷ VA, Obligations Policy, vol. II, chap. 5, January 2018.

dates that services were authorized. Home health agencies that provide care to veterans before medical facility personnel authorize the services may encounter delays in payments.

OCC Almost Always Paid Agencies Accurately for Authorized Services

The audit team estimated that at least 16,800 claims (or about 2 percent) from September 2018 through February 2019 had differences between the number of program service hours VHA authorized and the number of hours provided by home health agencies. Although this is a small percentage, this inconsistency in billable hours exposes VHA to the risk of paying agencies either too much or too little.⁶⁸ The team estimated that at least 23,600 (or about 2 percent) of the payments OCC made during the same time period were duplicative.⁶⁹ Due to the variability of this projection and the small sample size, the audit team conservatively reported the lowest level of the confidence interval while still reporting on the potential number of claims not paid accurately during the review period. VA Financial Healthcare Service personnel reported that their new Electronic Claims Adjudication Management System, a VA community care claims processing software system, should help to identify more duplicate claims. They reported that the system will either deny a claim that meets established duplicate payment criteria or suspend the claim for a claims processor or other user to review. The team could not evaluate this system's capabilities because it was not yet in use during the audit's review period.

Finding 2 Conclusion

OCC is estimated to have processed more than half of the homemaker and home health aide program claims within 30 days and with high accuracy. Although the error rate is small, the audit team estimated that OCC made at least about \$8.5 million in improper payments to home health agencies from September 2018 through February 2019. Some improper payments were duplicate payments, while others were due to documentation issues or authorization errors. VA's Electronic Claims Adjudication Management System reportedly has capabilities that should either maintain the small error rate observed by the team or further reduce it.

⁶⁸ The audit team identified overpayments and potential underpayments to home health agencies. This estimate is rounded for reporting purposes. Appendix C details the statistical sampling methodology, projections, and margins of error for the audit.

⁶⁹ This estimate is also rounded for reporting purposes.

Recommendations 6–8

The OIG recommended the under secretary for health take the following actions:⁷⁰

6. Review homemaker and home health aide program claims identified in the audit sample that involved improper payments made to home health agencies and recover funds if deemed necessary.
7. Assess the timeliness of homemaker and home health aide program claim payments and take corrective action as necessary.
8. Make sure there is sufficient monitoring of processed homemaker and home health aide program claims to mitigate the risk of paying claims not consistent with the corresponding authorizations.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with Recommendations 6 through 8 of the report. To address Recommendation 6, the executive in charge reported OCC's Payment Operations and Management will take corrective action on all sampled claims with errors. To address Recommendation 7, the executive in charge reported Payment Operations and Management will also assess the current timeliness of program claims that are processed through its Electronic Claims Adjudication Management System. If program claims are not processed in a timely manner, Payment Operations and Management will take actions to address delays and will provide the OIG with a timeliness report of program claims processed through the electronic claims management system. To address Recommendation 8, the executive in charge reported FBCS did not have adequate controls to prevent payments that were not authorized in advance. OCC's Payment Operations and Management now has systems in place to alleviate the risk of paying claims that are inconsistent with the corresponding authorizations. When the recommended action is completed, Payment Operations and Management will provide the OIG with documentation detailing the specific logic (error code) that flags authorizations and claims mismatches in the electronic claims management system.

OIG Response

The executive in charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing

⁷⁰ Recommendations directed to the under secretary for health were submitted to the executive in charge who has the authority to perform the functions and duties of the under secretary.

the intent of the recommendations and the issues identified. Appendix D includes the full text of the executive in charge's comments.

Appendix A: Background

Non-Institutional Care Program

VA's non-institutional extended care is provided in an outpatient or home setting. VHA defines this care as encounters that occur within the community, VA home-based health care, and home telehealth. Purchased noninstitutional care includes homemaker and home health aide program services.

Prior OIG Reports

The OIG has issued five reports since 2013 involving homemaker and home health aide services.

- A June 2018 report, *Alleged Misuse of VA Position and Resources*, did not substantiate the allegation that a senior manager at a VA medical facility instructed a subordinate to provide the senior manager's family member with additional daily home-based primary care home nursing visits as well as additional fee-basis homemaker services.⁷¹ The OIG did not substantiate any of the allegations reviewed and made no recommendations.
- In a May 2017 report, *Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics [in] White City, Oregon*, the OIG did not substantiate the allegation that the homemaker and home health aide program was mismanaged. The OIG initially substantiated that the homemaker and home health aide program lacked appropriate oversight as the community care oversight committee did not have required attendance or documentation of relevant program issues as described in VHA and local policy. However, based on updated information received in 2016, the OIG noted new committee leadership, required attendance, and discussion of relevant program issues. Therefore, the OIG made no recommendations.⁷²
- *Consult Management Concerns in VA Greater Los Angeles Healthcare System* was a report released May 4, 2017, in which the OIG found deficiencies related to staff not monitoring the electronic waiting list for program services.⁷³ The OIG reported 34 percent of the reviewed consults were administrative (nonclinical) in nature; almost half (61 of 126) of the administrative consults were delayed. The OIG also noted that most delayed administrative consults were for homemaker and home health aide services, tissue examinations, and preoperative implant purchase for cataract procedures. These administrative consult delays had no clinical impact but resulted in the appearance of

⁷¹ VA OIG, *Alleged Misuse of VA Position and Resources*, Report No. 17-03802-197, June 13, 2018.

⁷² VA OIG, *Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon*, Report No. 15-01653-226, May 17, 2017.

⁷³ VA OIG, *Consult Management Concerns in VA Greater Los Angeles Healthcare System, Los Angeles, California*, Report No. 15-04681-228, May 4, 2017.

delay. The OIG made five recommendations, including a recommendation that the facility director ensure that staff monitor and address the care needs of patients on the program services electronic waiting list. The OIG closed these recommendations.

- In November 2015, the OIG released *Access and Oversight Concerns for Home Health Services [in the] Washington DC VA Medical Center*.⁷⁴ The OIG found that the facility had wait times exceeding a year for patients needing homemaker and home health aides. The inspection substantiated that multiple facilities across VHA had similar challenges with electronic waiting lists for purchased home and community-based services. The report also identified concerns with local program management and oversight. The OIG recommended VHA require facilities to develop action plans to address the care needs of patients on home and community-based services' electronic waiting lists. The OIG also recommended that the facility director ensure home and community-based services' staff comply with all elements of national and local policies and that oversight and management of these services is adequate and in compliance with national policies. The OIG closed these recommendations.
- In the 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 2012.⁷⁵ The OIG also projected that 114 VA medical facilities limited access to purchased home care services 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 could pay ineligible agencies about \$893.5 million and make about \$13.2 million in improper payments over the next five years. The OIG made recommendations to the under secretary for health about eligibility criteria, waiting lists, program oversight, and performance measures. The OIG closed these recommendations.

⁷⁴ VA OIG, *Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia*, Report No. 14-03823-19, November 16, 2015.

⁷⁵ VA OIG, *Audit of Selected Non-Institutional Purchased Home Care Services*.

Appendix B: Scope and Methodology

Scope

The audit team conducted its work from March 2019 through August 2020. The team's review of veteran participants focused on whether they received intended homemaker and home health aide program services and whether VHA accurately processed these claims. The review period included claims for payment for program services that VHA approved from September 2018 through February 2019. The team identified about 1.1 million claims for payment for program services that VHA approved during this time frame. VHA paid about \$331.1 million to home health agencies for these claims.

Methodology

To gain an understanding of the homemaker and home health aide program, the audit team examined relevant governing authorities and guidance including:

- Title 38 United States Code § 1720C, *Noninstitutional alternatives to nursing home care*
- Title 38 of the Code of Federal Regulations § 17.38, *Medical benefits package*
- VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*
- Deputy Under Secretary for Health for Operations and Management Memorandum, "Case Mix Tool for Personal Care Services," August 28, 2017
- Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services," May 23, 2014
- 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

In addition, the team reviewed VA's Fee Basis Claims System User Manual to gain an understanding of the information system used to manage claims processing.

To learn about program operations, including how VHA oversees and manages the program, the audit team interviewed the director of the Office of Geriatrics and Extended Care (GEC) operations and the GEC chief of community care programs. The team also interviewed the director of Claims Adjudication and Reimbursement and four program personnel from the Office of Community Care (OCC) about processing payments made to home health agencies and

associated quality assurance procedures.⁷⁶ For more information on how OCC manages and monitors program wait times and electronic waiting lists, the team interviewed three OCC program personnel, including the operations director and director of policy and planning. The team interviewed eight OCC program personnel for information about the licenses for home health agencies that provide program services to veterans. Three OCC program personnel, including the financial oversight director, explained issues related to the budget for community care and the program. In addition, the team learned more about the Veterans Equitable Resource Allocation model and how it relates to program budgeting by interviewing two officials from VA's Allocation Resource Center. The team interviewed VHA Support Service Center personnel about noninstitutional care and waiting list reports, and collected and analyzed information about these reports from the appropriate VHA personnel. Although the Electronic Claims Adjudication Management System was not fully implemented at the time of the audit, the team interviewed OCC and VA Financial Healthcare Service officials and personnel about the system.

The team also interviewed representatives from 15 home health agencies nationwide about serving veterans in the program and any experiences with delays in VA reimbursements.

Site Visits

The audit team visited three VHA medical facilities. The team selected the following sites based on factors such as location and program size:

- **Edith Nourse Rogers Memorial Veterans Hospital.** Between November 2018 and April 2019, the audit team conducted interviews at the hospital in Bedford, Massachusetts. The team interviewed officials and personnel from VISN 1 to gain their perspectives on the program and how the budget process works in the network. Program officials and personnel described the development of the program budget and provided information about the facility's program and how program claims are processed.
- **North Florida/South Georgia Veterans Health System.** In May 2019, the audit team conducted a site visit to the health system in Lake City and Gainesville, Florida. The team interviewed personnel from VISN 8 and program officials and personnel about the facility's program, how program claims are processed, and the development of the program budget. In addition, the team interviewed veterans and a caregiver of another veteran in the program to learn about the services they received through the program.
- **VA New Jersey Health Care System.** In June 2019, the audit team conducted a site visit to the healthcare system in Lyons, New Jersey. The team interviewed personnel from VISN 2 to gain their perspectives on the program and how the budget process works in

⁷⁶ VHA OCC personnel reported to the audit team that in April 2019 that Claims Adjudication and Reimbursement had been renamed Payment Operations and Management.

the network. In addition, the team interviewed program officials and personnel about the program and how program claims are processed at the facility.

Additional site interviews:

- The audit team interviewed program officials at the VA Maine Healthcare System in Augusta, Maine, and the VA Salt Lake City Health Care System in Utah about how they manage and oversee their facilities' programs.
- The team also interviewed program personnel at the following eight facilities about how they manage their electronic waiting lists: the Albany Stratton VA Medical Center, Syracuse VA Medical Center, and Northport VA Medical Center in New York; the VA Puget Sound Health Care System in Seattle, Washington; the VA Greater Los Angeles Healthcare System in California; the VA New Jersey Health Care System in Lyons, New Jersey; the Salem VA Medical Center in Virginia; and the Manchester VA Medical Center in New Hampshire.
- In addition, the team interviewed program personnel at two medical facilities about how they manage program consults: the VA North Texas Health Care System in Dallas and the St. Cloud VA Health Care System in Minnesota.

Surveys of VHA Personnel about Program Services

The audit team conducted an online survey from May 10 through May 31, 2019, of 141 personnel at medical facilities providing program services. This survey was designed to collect information on program organizational alignment, guidance, electronic waiting lists, quality oversight, home health agency selection, fraud, and other challenges. The team surveyed medical facility personnel with responsibilities for the day-to-day management and/or operations of the program. The response rate was about 86 percent.

From June 19 through July 29, 2019, the audit team conducted another online survey of the 18 program leads at all VISNs. The survey for the program leads was designed to collect information on program oversight, monitoring, and reporting. The response rate was 100 percent.

Home Health Agencies Licensure and Certification Review

To determine whether home health agencies providing program services to veterans had proper licensing or certifications, the audit team reviewed a random sample of 200 claims for payment for program services that VHA approved from September 2018 through February 2019. Based on this review, the team identified the number of unique agencies providing services to

participating veterans during this time period. The team used the agencies' National Provider Identifier numbers to determine the agencies to review.⁷⁷

From July through August 2019, the audit team reviewed the licensing or certifications for 177 unique agencies to ensure they were complying with state requirements for program services. The review included searching VA's two online licensure and certification documentation repositories in use at the time. Some medical facilities may have either exempted or locally approved agencies that met the conditions included in VHA guidance, but did not report this information to GEC or a VISN director as required.⁷⁸ Therefore, the team reported the improper payments made to these agencies as up to an estimated \$145.4 million. In addition, the team assessed the documentation provided by OCC and medical facility personnel to determine whether these agencies had valid licenses or certifications when they provided program services to veterans during the review period.

Based on an OIG legal review completed in November 2019, the team identified and excluded all agencies in the eight states where licenses were not required to provide program services to veterans (Alabama, Iowa, Massachusetts, Michigan, Ohio, South Dakota, Vermont, and West Virginia). The team also included one agency in its review that served veterans in Washington, DC, where agencies are required to be licensed prior to providing services. In addition, the team included five agencies in its review that served veterans in Puerto Rico because the territory had local health requirements for agencies providing program services to veterans.

In September 2019, the team shared the results of its review with an OCC subject matter expert familiar with licenses. The expert reviewed these results with the team to validate the number of unlicensed or uncertified home health agencies that served veterans during the review period.

Local Policy Review

To gain an understanding of program implementation and operation at medical facilities, the audit team contacted VISN and program personnel at 141 medical facilities about their local policies and practices involving the homemaker and home health aide program. From July through October 2019, the team considered the 100 local policies and practices that were provided by program personnel. In addition, the team interviewed GEC's chief of community care programs and medical facility program personnel at various medical facilities.

⁷⁷ As a result of the Health Insurance Portability and Accountability Act of 1996, the Department of the Health and Human Services adopted the National Provider Identifier as the standard to identify individual healthcare providers. Providers apply for this unique 10-digit number to identify themselves in a standard way throughout the industry.

⁷⁸ VHA, "Reinforcement and Clarification of Requirements for Quality Oversight and Monitoring of Purchased Home Care Services."

Program Consult Review

Ninety-nine of the medical facilities that responded to the audit team's national survey reported their facilities did not maintain a VHA electronic waiting list for the homemaker and home health aide program. To determine whether veterans experienced delays when VHA electronic waiting lists were not used, the team requested consult data for these 99 facilities. Because of the different ways in which program consult data were tracked by facilities that do not maintain a VHA electronic waiting list, the team was only able to obtain the program consult data for 45 of the facilities. The team then contacted the 45 facilities and requested any pending, active, and scheduled program consult data as of August 2019. In addition, the team requested information on the systems used to extract the consult data for requests and, if applicable, an explanation for the number of pending consults. The team conducted a review of consult data and other information provided by the 41 facilities that responded to the team's request. Because of the different ways that medical facilities name and manage program consults, the team could not assess the reliability of this data. Consequently, the team attributed this data only to the medical facilities that provided it.

Program Claims Processing Review

The audit team developed an electronic data collection instrument to review a random sample of 200 program claims approved from September 2018 through February 2019. These claims represented 199 unique veterans receiving homemaker and home health aide program services from 177 home health agencies. These claims accounted for about \$53,300 in program services. The instrument captured the elements required by VHA Handbook 1140.6. The team used this instrument to review data in VA's Computerized Patient Record System on the authorized program services, as well as approved claim data in FBCS. In addition, the team used this instrument to identify potential deficiencies in the following areas: authorization of program services by VHA facility personnel, delivery of services by home health agencies, and processing of program claims by VHA claims personnel.

After an initial review of 35 program claims using a data collection instrument, the audit team focused on timesheets, authorization information, and claims data. The team evaluated whether veterans received authorized services from home health agencies and whether VHA accurately authorized and processed claims. The team conducted this review using program claims data and documentation. The team also reviewed 173 timesheets for the claims in the audit sample. Facilities did not provide timesheets for 27 claims. In September 2019, the team shared the results of the program claims review with OCC personnel familiar with claims processing and discussed these results with them. OCC shared these results with program personnel in the field. In some cases, field personnel provided additional documentation explaining the identified deficiencies. After considering this documentation, the team updated the results of its program claims review as appropriate.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur within the context of the audit objective.

Alert to these risks, the team exercised due diligence in taking the following actions:

- The team coordinated with the OIG's Office of Investigations concerning potential fraud indicators.
- The team examined the survey results reported by program contacts to identify potentially fraudulent activities involving program participants.
- The team considered potential fraud indicators when reviewing claim payment files.

The OIG identified 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 FBCS data for homemaker and home health aide claims for program services that VHA approved from September 2018 through February 2019. In addition, the team worked to determine if FBCS data were sufficient for selecting a random sample of claims. The team also assessed the reliability of VA's Financial Management System data to determine if the data were sufficient for calculating payments that VHA made to home health agencies providing services to veterans during this time period.

The audit team tested FBCS data by verifying that veteran payment information was maintained in the system. In addition, the team compared FBCS data with veterans' information contained in payment files, including claims payment documentation. The team also compared payment data from FBCS to information from VA's Financial Management System to identify incorrect or incomplete information. The team included data reliability questions in the data collection instrument used during the audit as an additional verification of the data obtained from FBCS. Furthermore, the team verified the accuracy of information collected from payment files in FBCS with program contacts at selected medical facilities. The team also discussed the reliability of payment data captured in FBCS and the Financial Management System with responsible personnel.

The audit team incorporated second-level reviews of the analysis of claims payment files. In addition, the team reviewed the results of its claims review with the appropriate OCC officials and considered additional claims documentation provided by VHA. OCC officials agreed with the result of the team's reviews. Based on this reliability assessment, the team concluded that data in FBCS and the Financial Management System were appropriate and sufficient for the 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 sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

Sampling Methodology

The audit team used the VHA Support Service Center's *Non-Institutional Care Trend Report* to identify the number of claims, dollar amounts, and number of unique veterans for FY 2018.⁷⁹ The team also identified VHA GEC-reported data from 2017 to 2019 on medical facilities with electronic waiting lists; the percentages of veterans residing in urban and rural areas in 2018 reported by VHA's Office of Rural Health; and states with mandated training or licensing requirements as reported by PHI, a nonprofit research and consulting organization, to identify OIG risk groups for program claims.⁸⁰ The team developed an OIG risk matrix that stratified medical facilities into high-, medium-, and low-risk groups for sampling homemaker and home health aide program claims from September 1, 2018, through February 28, 2019.

The audit team obtained FBCS data from VHA's Corporate Data Warehouse to identify approved program claims during the review period. About 1.1 million claims were approved during this time period. This universe included all 129 medical facilities that approved homemaker and home health aide program claims. The team stratified this universe of claims using the risk grouping and randomly selected 200 claims to review.⁸¹ Table C.1 illustrates the total number of program claims stratified by risk, as well as the number of sampled claims in each risk group.

Table C.1. Approved Program Claims by OIG Risk Groups

Risk group	Claims	Percent	Samples	Sampling weights
High	532,785	47.97	115	4,633
Medium	224,629	20.22	45	4,992
Low	353,310	31.81	40	8,833
Total	1,110,724	100	200	

Source: VA OIG analysis of homemaker and home health aide program claims approved from September 1, 2018, through February 28, 2019.

⁷⁹ VHA Support Service Center, *Non-Institutional Care Trend Report*, obtained in October 2018.

⁸⁰ PHI, Home Health Aide Training Requirements, December 2016.

⁸¹ The audit team's sample represents 200 unique claims for 199 unique veterans.

Table C.2 reflects the characteristics of the audit team’s random sample of 200 approved program claims.

Table C.2. Characteristics of OIG Sample of 200 Approved Program Claims

Characteristic	
Number of unique veterans	199*
Number of medical facilities	76
Number of home health agencies	177
Total dollar value of program claims	\$53,338
Minimum program claim value	\$21
Maximum program claim value	\$2,464
Earliest date of service	January 20, 2015
Latest date of service	January 27, 2019

Source: VA OIG analysis of 200 randomly sampled homemaker and home health aide program claims approved from September 1, 2018, through February 28, 2019.

**The sample included one veteran with two approved program claims.*

Weights

The audit team calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The team used the weights to compute estimates. For example, the team calculated the error rate point estimates by summing the sampling weights for all sample cases that contained the error, then dividing that value by the sum of the weights for all sample cases.

Projections and Margins of Error

The point estimate (or 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 OIG 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 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 decreases as more records are added to the sample review.

Tables C.3, C.4, and C.5 detail the audit projections related to the use of unlicensed or uncertified home health agencies, payment timeliness, unsupported claims, delinquent obligations, authorization inconsistencies, and duplicate and improper payments. These projections are the basis of the estimated potential monetary benefits for the audit detailed in appendix E.

Table C.3. Statistical Projections—Use of Unlicensed and Uncertified Home Health Agencies

Results	Sample results	Estimate	Margin of error	90% confidence interval lower level	90% confidence interval upper level
Number of home health agencies without valid licenses or certifications that submitted claims during the review period*	103	3,290 (50%)	444 (7%)	2,846 (44%)	3,734 (57%)
Number of program claims submitted by home health agencies without valid licenses or certifications to provide services	103	545,677 (49%)	66,560 (6%)	479,117 (43%)	612,236 (55%)
Improper payments	103 [†]	\$145,410,051	\$31,912,301	\$113,497,750	\$177,322,352

Source: OIG analysis of a random sample of 200 program claims for 177 home health agencies from September 1, 2018, through February 28, 2019.

Note: Some numbers in the table were rounded for reporting purposes. The audit team’s analysis of unlicensed and uncertified agencies may have included some agencies that met the conditions in VHA guidance or were exempted locally but were not forwarded to the proper VHA personnel for approval as required.

**The number of home health agencies without valid licenses or certifications includes agencies that submitted more than one program claim during the review period.*

†The team considered payments to these home health agencies to be improper, but not recoverable.

Table C.4. Statistical Projections—Timeliness of Claims Payment Processing

Results	Sample results	Estimate	Margin of error	90% confidence interval lower level	90% confidence interval upper level
Payments made on time	108	598,493 (54%)	67,090 (6%)	531,403 (48%)	665,582 (60%)
Payments not made on time	92	512,232 (46%)	67,090 (6%)	445,142 (40%)	579,321 (52%)
Payments made between 31 and 35 days	45	243,621 (48%)	55,062 (9%)	188,559 (39%)	298,684 (57%)
Payments made between 36 and 45 days	17	97,353 (19%)	39,195 (7%)	58,158 (12%)	136,548 (26%)
Payments made between 46 and 90 days	24	130,142 (25%)	43,310 (8%)	86,832 (18%)	173,453 (33%)
Payments made after 90 days	6	41,115 (8%)	28,251 (5%)	12,864 (3%)	69,365 (13%)

Source: *OIG analysis of a random sample of 200 program claims from September 1, 2018, through February 28, 2019.*

Note: *Some numbers in the table were rounded for reporting purposes.*

Table C.5. Statistical Projections—Program Claims Review Results

Results	Sample results*	Estimate	Margin of error	90% confidence interval lower level	90% confidence interval upper level
Claims without adequate support	34	197,112 (18%)	53,016 (5%)	144,096 (13%)	250,128 (23%)
Delinquent obligations	30	149,540 (14%)	42,770 (4%)	106,770 (10%)	192,310 (17%)
Authorization inconsistencies	8	41,622 (4%)	24,848 (2%)	16,774 (2%)	66,470 (6%)
Duplicate payments	9	54,296 (5%)	30,704 (3%)	23,591 (2%)	85,000 (8%)
Improper payments	19 [†]	\$33,377,690	\$24,889,921	\$8,487,769	\$58,267,610
Improper and recoverable payments	15	\$11,408,915	\$5,888,786	\$5,520,130	\$17,297,701

Source: OIG analysis of a random sample of 200 program claims from September 1, 2018, through February 28, 2019.

*The results reflect individual counts of deficiencies out of the total sample of 200 program claims. One program claim could have multiple deficiencies. Some numbers in the table were rounded for reporting purposes.

[†]Fifteen of the 19 deficient claims included three claims with authorization errors, nine duplicate payments, and three unsupported claims with overpayments. The audit team considered payments made related to these deficient claims to be improper, as well as recoverable, if VHA decides to take action. The remaining four deficient claims included in the estimate are unsupported claims. The team considered payments made related to these claims to be improper, but not recoverable.

Appendix D: Management Comments

Department of Veterans Affairs Memorandum

Date: September 16, 2020

From: Executive In Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Veterans Health Administration Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans (Project Number 2019-07316-R1-0004) (VIEWS 03518361)

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

Thank you for the opportunity to review the draft report on the Veterans Health Administration (VHA) Homemaker and Home Health Aide Program. The Geriatrics and Extended Care (GEC) is pleased to participate in a new system that will replace the electronic waitlist and improve Veterans' access to homemaker/home health aide services. Additionally, GEC welcomes the use of the community care network to improve access to supply community homemaker and home health aide providers.

I concur with the draft report and provide the attached action plan to address the recommendations. VHA completed work on recommendation 2 and asks OIG to consider closure. The attached action plan provides implementation details and documentation in support of the closure request.

The OIG removed point of contact information prior to publication.

(original signed by)

Richard A. Stone, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

**OIG Draft Report: VETERANS HEALTH ADMINISTRATION: Homemaker and Home Health Aide
Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans**

Date of Draft Report: August 21, 2020

Recommendations/Actions	Status	Target Completion Date
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Recommendation 1. Assess whether current program policies and practices meet the needs of medical facilities' local homemaker and home health aide programs and update them as necessary.

Comments: Concur. The Veterans Health Administration (VHA) recognizes that guidance has not been published on the Homemaker/Home Health Aide Program since 2014. VHA recognizes that updated guidance should be published. To implement this recommendation, the VHA Office of Geriatrics and Extended Care (GEC) will publish a sub-section, to include the Homemaker/Home Health Aide Program, in the Office of Community Care Field Guidebook, Specialty Programs Chapter, GEC Section 1.2.

Status: In Progress

Target Completion Date: January 2021

Recommendation 2. Make certain that homemaker and home health aide program guidance is updated to include processes that medical facilities must follow when assessing whether home health agencies are licensed or certified, meet specified conditions, or will be exempted from program requirements, to include determining a mechanism to track data on these decisions locally and nationally.

Comments: Concur. The Veterans Health Administration (VHA) Office of Geriatrics and Extended Care (GEC) published guidance detailing the community provider standards for purchased long term services to include homemaker/home health aide providers, in the VHA Office of Community Care (OCC) Field Guidebook, Specialty Programs Chapter, GEC Section 1.2 on July 23, 2020. This document lists criteria to use when credentialing homemaker/home health aide providers and speaks to verifying "home health agencies are licensed or certified, meet specified conditions, or will be exempted from program requirements."

Homemaker/home health aide providers in the community care network are credentialed by the third-party administrator, according to the contracts between the third-party administrators and VHA. This credentialing includes verifying "home health agencies are licensed or certified, meet specified conditions, or will be exempted from program requirements."

Homemaker/home health aide providers with Veterans Care Agreements (VCA) are credentialed by the VHA OCC VCA Review Team, according standard operating procedures initially published May 14, 2019, and most recently updated June 5, 2020, and this credentialing is documented following the processes detailed in the VHA OCC Provider Profile Management System (PPMS) User Functionality Standard Operating Procedures. This credentialing process includes verifying "home health agencies are licensed or certified, meet specified conditions, or will be exempted from program requirements, to include...[tracking] data on these decisions locally and nationally." VHA considers actions on this recommendation complete and asks OIG to consider closure.

Status: Complete

Recommendation 3. Make certain that homemaker and home health aide program guidance is updated to include procedures that medical facilities must follow (1) to determine the suitability of veterans for program services; (2) when they cannot meet veterans' program needs within the required period of time because of facility or community resource constraints; and (3) to inform the management of their program resource needs.

Comments: Concur. The Veterans Health Administration (VHA) recognizes that VHA has not published guidance on the Homemaker/Home Health Aide Program since 2014, and VHA recognizes that updated guidance should be published. To implement this recommendation, the VHA Office of Geriatrics and Extended Care (GEC) will publish a sub-section, to include the Homemaker/Home Health Aide Program, in the Office of Community Care Field Guidebook, Specialty Programs Chapter, GEC Section 1.2.

GEC will refer medical facilities to follow current national direction from the Assistant Under Secretary for Health for Operations (memorandum on Simplification of New Patient Scheduling and Elimination of the VHA Electronic Wait List (EWL)) and any subsequent policy established by the VHA Office of Veterans Access to Care (OVAC) on managing circumstances when "medical facilities...cannot meet veterans' program needs within the required period of time because of facility or community resource constraints." This reference will be included in the Office of Community Care Field Guidebook, Specialty Programs Chapter, GEC Section 1.2.

GEC requires more information on the reports of open consults that replace the EWL to ensure that medical facilities are aware of the status of their homemaker/home health aide program, including "program resource needs." GEC will formulate a specific action plan, if required, once VHA policy on this topic is issued.

Status: In Progress

Target Completion Date: January 2021

Recommendation 4. Implement procedures for medical facility directors to use data on veteran demand, including unmet demand, for homemaker and home health aide program services to inform the management of program resources locally.

Comments: Concur. The Veterans Health Administration (VHA) Office of Geriatrics and Extended Care (GEC) requires more information on the reports of open consults that replace the Electronic Wait List to ensure that medical facilities are aware of the status of their homemaker/home health aide program, including "program resource needs." GEC will formulate a specific action plan, if required, once VHA policy on this topic is issued.

Status: In Progress

Target Completion Date: January 2021

Recommendation 5. Make certain that homemaker and home health aide program guidance is updated to include processes that medical facilities must complete when veterans with care needs have been refused services from home health agencies because of demonstrated behavioral issues.

Comments: Concur. The Veterans Health Administration (VHA) recognizes that VHA has not published guidance on the Homemaker/Home Health Aide Program since 2014. VHA recognizes that updated guidance should be published. To implement this recommendation, the VHA Office of Geriatrics and Extended Care (GEC) will publish a sub-section, to include the Homemaker/Home Health Aide Program, in the Office of Community Care Field Guidebook, Specialty Programs Chapter, GEC Section 1.2.

Status: In Progress

Target Completion Date: January 2021

Recommendation 6. Review homemaker and home health aide program claims identified in the audit sample that involved improper payments made to home health agencies and recover funds if deemed necessary.

Comments: Concur. Payment Operations and Management (POM) recognizes the effect erroneously processed claims may have on Veterans and providers and takes seriously the importance to pay claims timely and accurately. As mentioned in the second finding of the audit, the audit team identified nineteen incorrectly processed claims, which require correction. POM will take corrective action on all sample claims identified as being improperly adjudicated. To demonstrate completion POM will provide the sample listing, review and actions taken to resolve each error OIG identified in its audit.

Status: In Progress

Target Completion Date: November 2020

Recommendation 7: Assess the timeliness of homemaker and home health aide program claim payments and take corrective action as necessary.

Comments: Concur. While Payment Operations and Management (POM) was successful in paying claims in a timely manner for more than half of the claims in the audit, POM agrees opportunities exist to improve payment processes. POM will collaborate with the Electronic Claims Adjudication Management System (eCAMS) program manager to determine current timeliness of Homemaker Home Health Aide (HHA) claims processing. If it is determined that HHA claims are not auto adjudicating in a timely manner, POM will work on solutions to improve processing time and collaborate with the eCAMS program manager as well as the Financial Services Center (FSC) to improve. At completion of the corrective action taken, POM will provide a report of eCAMS HHA claims indicating overall timeliness.

Status: In Progress

Target Completion Date: November 2020

Recommendation 8: Make sure there is sufficient monitoring of processed homemaker and home health aide program claims that would mitigate the risk of paying claims not consistent with the corresponding authorizations.

Comments: Concur. The POM legacy claims processing system, Fee Basis Claim System (FBCS), did not have a sufficient control to prevent payments that were not authorized in advance. POM now has systems in place that alleviate the risk of paying claims not consistent with the corresponding authorizations. POM's new automated claims adjudication system, Electronic Claims Adjudication Management System (eCAMS), prevents the claim from auto adjudicating if an authorization mismatch is found.

If a claim is received without an authorization or a discrepancy from the approval on file, the system immediately isolates the claim, assigning an error code, which is reviewed and acted on by a claims processor in POM. For instance, if a claim is received and the corresponding approval on file does not have the same number of allowable visits, the claim is immediately halted, and reviewed. At completion of this recommendation, POM will provide the Office of Community Care's eCAMS error list job aid which contains the specific logic (error code) that flags authorization/claims mismatch.

Status: In Progress

Target Completion Date: November 2020

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
2	Value of improper payments that VHA made for a random sample of 200 program claims processed without valid licenses or certifications from September 1, 2018, through February 28, 2019		\$145,410,051
6 and 8	Value of improper payments that VHA made for a random sample of 200 program claims with deficiencies from September 1, 2018, through February 28, 2019		\$8,487,769
	Total	\$0	\$153,897,820

The top estimate of up to about \$145.4 million in questioned costs is related to OCC’s payments to agencies that lacked valid licenses or certifications during the review period. Appendix B provides details on these payments. It is based on 103 of 200 randomly selected program claims submitted by home health agencies without valid licenses or certifications identified in the audit team’s sample. This estimate is projected to a universe of 1.1 million claims totaling \$331.1 million. The team considered payments to these agencies to be improper, but not recoverable.

The bottom estimate of about \$8.5 million is based on 19 of 200 randomly selected program claims that the audit team determined were deficient. This estimate is projected to a universe of 1.1 million claims totaling \$331.1 million. Fifteen of these deficient claims included three claims with authorization errors, nine duplicate payments, and three unsupported claims with overpayments. The team considered payments made related to these deficient claims to be improper, as well as recoverable, if VHA determines it is appropriate to take action. The remaining four deficient claims included in the estimate are unsupported claims. The team considered payments made related to these claims to be improper, but not recoverable.

Due to the variability of this projection and the small sample size, the audit team reported the lowest level of the confidence interval to demonstrate to VA the potential risk to VHA resources

using the most conservative projected numbers. Appendix C provides details on the statistical sampling methodology, projections, and margins of error for the audit.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Audit Team	Irene J. Barnett, Director Daniel Blodgett Candice-Monique Brown Henry Chan Marco Chan Abigail Genitempo Lee Giesbrecht Benjamin Howe Nyquana Manning Joseph Vivolo
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Other Contributors	Kathryn Berrada Katharine Brown
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