

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Audit of
Selected Non-Institutional
Purchased Home
Care Services*

September 30, 2013
11-00330-338

ACRONYMS AND ABBREVIATIONS

ADC	Average Daily Census
CMS	Centers for Medicare and Medicaid Services
GAO	Government Accountability Office
GEC	Office of Geriatrics and Extended Care
NIC	Non-Institutional Care
OIG	Office of Inspector General
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Highlights: Audit of Selected VHA Non-Institutional Purchased Home Care Services

Why We Did This Audit

We assessed whether the Veterans Health Administration (VHA) effectively managed non-institutional purchased home care services to ensure eligible veterans receive entitled services. We audited these services because of their expected growth, budgeted to increase to \$798 million in FY 2013.

What We Found

We estimated VHA's waiting lists did not include at least 49,000 veterans who had purchased home care needs in FY 2012. We projected that 114 VA medical facilities limited access to purchased home care services through the use of more restrictive eligibility criteria than VHA policy required, applying nonstandard review processes, and relying on inaccurate and nonstandard eligibility information. VA facilities added requirements to limit veterans' access and did not always use required waiting lists to track eligible veterans.

This occurred because VA medical facility officials limited the costs of services paid through fee service, relied on inaccurate eligibility information for skilled care services, and redirected funds towards higher priorities. VHA redistributed \$76 million, VA medical facilities spent \$99 million less than VA had budgeted for these services, and VHA did not meet its target to increase the average daily census for these services in FY 2012.

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 5 years.

What We Recommended

We recommended the Under Secretary for Health standardize the application of eligibility reviews and criteria and strengthen controls to ensure eligible patients receive purchased home care services. We also recommended the adequate review and monitoring of agencies and proper documentation and use of orders to verify payments.

Agency Comments

The Under Secretary for Health concurred with our recommendations and provided responsive action plans. We will follow up on these actions. The Under Secretary has concerns about the sampling methodology and statistical analysis of our report. These concerns are addressed in Appendix G.

A handwritten signature in blue ink that reads "Linda A. Halliday".

LINDA A. HALLIDAY
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INTRODUCTION

Objective

This audit assessed whether the Veterans Health Administration (VHA) effectively managed selected non-institutional purchased home care services to ensure eligible veterans received appropriate services.

Non-Institutional Care Program and Purchased Home Care Services

VHA's non-institutional care (NIC) program allows veterans to receive VA and contractor-provided services in the least restrictive environment possible. Under home based primary care, multidisciplinary VA caregiver teams monitor and care for veterans with complex and chronic health care issues in their homes. In addition, veterans may also receive more specialized services, such as skilled care and homemaker/home aide, in their homes from contracted agencies. This audit examined the following contracted non-institutional purchased home care services: skilled care, homemaker/home aide, respite care, and hospice services. In this report, "purchased home care" refers to skilled care, homemaker/home aide, and respite care because we did not identify issues with hospice services.

Program Office Responsibilities

The Office of Geriatrics and Extended Care (GEC) provides policy direction for the development, coordination, and overall integration of VHA's NIC program. GEC also establishes NIC average daily census (ADC) targets for each Veterans Integrated Service Network (VISN) to encourage the expansion of NIC services, including purchased home care. The ADC represents the average daily number of patients who have been provided services. Each VISN establishes NIC ADC targets for their individual medical facilities. VHA requires VA medical facilities to place veterans in need of purchased home care services on electronic waiting lists when services cannot be provided due to funding constraints.

Program Magnitude

In FY 2012, purchased home care, to include hospice, constituted \$756 million (47 percent) of VA's \$1.6 billion NIC budget. The budget for homemaker/home aide, respite, and skilled care services was \$676 million, and hospice's budget was \$80 million. However, VHA only provided the VISNs \$599 million for homemaker/home aide, respite, and skilled care and \$74 million for hospice. According to GEC, VISN budgets were reduced by \$83 million after the ADC targets for these services were reassessed and lowered. In FY 2012, VA medical facilities spent about \$501 million to provide homemaker/home aide, respite, and skilled care and \$66 million to provide hospice services. During FY 2012, VHA provided about 127,000 unique patients purchased home care services, to include hospice, and reported an ADC of 23,300 patients. In FY 2013, the four purchased home care services are expected to cost about \$798 million.

Other Information

- Appendix A provides additional background information.
- Appendix B provides information on the audit's scope and methodology.

RESULTS AND RECOMMENDATIONS

Finding 1 VHA Limited Eligible Veterans' Access to Selected Purchased Home Care Services

We estimated that VHA's waiting lists did not include 49,000 veterans who needed homemaker/home aide, respite, and skilled care services in FY 2012. The majority of the eight VA medical facilities we reviewed did not consistently use waiting lists to track veterans in need of these purchased home care services. Further, the eight VA medical facilities we reviewed improperly limited eligible veterans' access to these selected purchased home care services. We projected that about 114 VA medical facilities limited access to these services because they applied more restrictive eligibility criteria and/or review processes, and in some cases, relied on inaccurate eligibility information.

VHA and VA medical facility staff limited veterans' access to these selected purchased home care services because:

- In some cases, VA medical facilities reduced the funding for these services to contain the costs of services paid through fee service and to make funding available for higher priorities. These VA medical facilities considered purchased home care services part of their local fee care budgets and made the reduction or containment of fee service costs a rating element in the performance plans of some staff who evaluated patients' eligibility for purchased home care services.
- Various VA published resources contained inaccurate information about the eligibility requirements for purchased skilled care services.
- GEC lacked adequate oversight and monitoring mechanisms for the provision of homemaker/home aide, respite, and skilled care services.

As a result, VA medical facilities spent \$99 million less than the \$599 million VHA had allotted or about \$175 million less than the \$676 million Congress approved for homemaker/home aide, respite, and skilled care services in VA's FY 2012 budget. The \$99 million was redirected by senior officials at the VA medical facilities, such as the medical facility directors and chief financial officers, to address other unidentified VA medical facility needs.

The remaining \$76 million was redistributed by VHA and was not sent to the VISNs for providing purchased home care services. VHA also did not meet its target to expand access and increase its FY 2012 ADC for these services

**Criteria for
Purchased
Home Care
Services**

by a little under 4,500 patients a day.¹ Further, VHA could not ensure its VA medical facilities provided one standard of care because of the application of disparate eligibility criteria and the lack of standardized review processes to assess veterans' eligibility for services at VA medical facilities.

VA primary care physicians and interdisciplinary care teams assess veterans' eligibility for purchased home care services. VHA policy requires them to use the following general criteria to assess veterans and to ensure the provision of the purchased home care services is medically necessary and appropriate.

To be eligible for homemaker/home aide or related respite care services, veterans must meet one of the following three criteria.

- Need assistance with activities of daily living such as bathing, toileting, personal care, and chores
- Be cognitively impaired
- Have other limiting health issues, such as advanced age or clinical depression

To be eligible for skilled care services, veterans must intermittently need one or more of the following services.

- Short-term or long-term skilled nursing assessment, teaching, treatment services, or monitoring
- Short-term or transitional rehabilitative therapies, such as physical therapy, speech and language pathology services, and occupational therapy
- Short-term or transitional social work services

To be eligible for home hospice services, veterans must meet the following criteria.

- Be diagnosed with a life-limiting illness
- Have treatment goals that focus on comfort rather than care
- Have a VA physician determine if the veteran's life expectancy is 6 months, or less
- Accept hospice care

¹ VHA's FY 2012 ADC target was about 24,500. Its ADC was 20,000 after we adjusted Veterans Support Service Center data to ensure patient counts for purchased home care services only reflected the number of visits, not the reported number of billed line items.

VHA policy requires VA medical facilities to immediately provide all eligible veterans with hospice services either in their home, a VA medical facility, or in a contracted community nursing home. Eligible veterans who require homemaker/home aide, respite, and/or skilled care services must be provided these services or be placed on waiting lists when VA medical facilities meet their ADC targets or cannot provide the needed services due to funding constraints.

Accurate and complete waiting lists allow VA medical facilities to monitor eligible veterans whose homemaker/home aide, respite, and/or skilled care needs have not been met so that these needs can be considered along with other funding priorities. Placement on a waiting list also ensures veterans have the opportunity to obtain needed services if funding becomes available or when other veterans no longer need services.

**Limiting
Access to
Purchased
Home Care**

The eight reviewed VA medical facilities used various methods and strategies to limit veterans’ access to homemaker/home aide, respite, and skilled care services. They limited access through the application of more restrictive local eligibility criteria and/or supplemental review processes that were more stringent than nationally prescribed criteria. Many of these same VA medical facilities did not maintain waiting lists because they used their stringent local requirements and/or review processes to justify the denial of services to otherwise eligible veterans.

Table 1 summarizes the purchased home care access issues identified at the eight medical facilities selected for review.

Table 1

Summary of Purchased Home Care Access Issues			
VA Medical Facility	Applied Stringent Local Criteria	Supplemental Review Processes	Did Not Maintain Waiting Lists
1	X	X	X
2		X	X
3	X		
4	X		
5		X	X
6	X		X
7	X		X
8			X
Total	5	3	6

Source: OIG analysis

Based on these results, we projected that approximately 114 of the 143 (79 percent) VA medical facilities limited access to homemaker/home aide, respite, and skilled care services. Of the 114 medical facilities, we projected that 91 VA medical facilities may have used more restrictive criteria and/or supplemental reviews to limit access to these services and a minimum of 63 facilities did not maintain waiting lists.

*Application of
More Stringent
Criteria*

Five of the eight VA medical facilities reviewed limited access to purchased home care services by applying more stringent eligibility criteria for services than those established by VHA policy. VHA's purchased home care policy is designed to make services accessible to those veterans who need them the most. VHA's policy reflects Congress' passage of the Veterans' Health Care Eligibility Reform Act in 1996, which expanded purchased home care services eligibility to include nonservice-connected disabled veterans. Despite VHA policy and the Eligibility Reform Act, VA medical facilities have added requirements related to the veterans' homebound status and/or service connection that limit veterans' access to these services.

Application of restrictive eligibility criteria varied based on the VA medical facility. For comparison,

- One VA medical facility required veterans to be homebound to be eligible for homemaker/home aide services.
- Another VA medical facility required veterans to have a service-connected disability rating of 50 percent or higher to be eligible for homemaker/home aide services.
- Another VA medical facility required veterans to be hospice patients or recently discharged skilled nursing facility patients with a high return risk and a service-connected disability rating of 50 percent or higher to be eligible for homemaker/home aide services.

The following examples show how veterans, eligible for homemaker/home aide services under VHA policy, were ineligible and denied access to the services under one medical facility's more restrictive criteria.

Example 1

A VA physician determined that a Vietnam War veteran with bone cancer needed a lift to get out of bed and assistance with daily living activities and was clinically eligible to receive homemaker/home aide services. However, the homemaker/home aide coordinator did not approve the services because the veteran was not a hospice patient or a recently discharged skilled nursing facility patient with a high return risk and service-connected disability rating of 50 percent or higher. Consequently, the homemaker/home aide supervisor recommended the veteran use Medicare to obtain the services and did not place the veteran on a waiting list because she was not considered eligible for the services at the VA medical

facility. At the time of our site visit, medical facility staff had not followed up to determine whether or not the veteran had received homemaker/home aide services through Medicare.

Example 2

Another VA physician at the same facility determined that a Korean War veteran, who was recently discharged from a non-VA nursing home and required the use of a lift to get out of bed and assistance with daily living activities, was clinically eligible to receive homemaker/home aide services. However, the homemaker/home aide coordinator denied the veteran services because he was not a hospice patient, and he had not been discharged from a skilled nursing facility. Consequently, the homemaker/home aide coordinator recommended the veteran return to the non-VA nursing home for services and did not place the veteran on a waiting list because he was not considered eligible for the services at the VA medical facility. At the time of our visit, medical facility staff did not know whether or not the veteran had returned to the non-VA nursing home.

*Use of
Non-Standard
Review
Processes*

Staff at three of the eight VA medical facilities we reviewed also used non-standard review processes to limit access to purchased home care services. VHA policy only requires a veteran's VA physician or clinical care team to assess the veteran's eligibility for these services and to submit a referral. Local VA medical facility managers may use additional reviews performed by staff, such as occupational therapists, the Chief of GEC, and/or fee program nurses at their facilities, to promote fiscal stewardship and to strengthen clinical decision making. However, based on interviews of staff at three VA medical facilities and our analysis of prior year performance data and plans, it is our opinion that the intent of the additional reviews was to limit access to these services and control fee program expenses. For example:

Example 3

Staff at one VA medical facility where these additional eligibility requirements were used indicated the added requirements caused them to discontinue services to eligible veterans when the facility needed to control its fee program costs. They had to refer these veterans to resources in the community or to Medicare in order to help the veterans receive these services.

Examples of the non-standard review processes these VA medical facilities used to limit veterans' access to purchased home care services follow.

Example 4

Veterans at one VA medical facility were required to see an occupational therapist after their clinical care teams assessed them and determined they were eligible for homemaker/home aide services. The occupational therapists' assessment scores, along with the clinical care teams' initial assessments, were given to the

facility's Chief of GEC for review. In some cases, the Chief of GEC decided the veterans were ineligible for the services based on the occupational therapists' scores and despite the assessments of the veterans' clinical care teams.

Example 5

Veterans at another VA medical facility were evaluated by a fee program nurse after their clinical care teams and the skilled care coordinator had evaluated them and determined they were eligible for skilled care. The fee program nurse reviewed the veterans' medical records to determine if community resources could provide the care and to assess the veterans' degree of "medical necessity." The nurse's review included various factors, such as whether or not the veterans had the ability to travel to a VA facility or clinic for the needed services. Veterans, who could obtain the purchased home care services from other community sources or, in the case of skilled care, could travel to a VA medical facility or clinic for the services, were deemed ineligible. These veterans could not receive the necessary services in their homes even though they met VHA eligibility criteria.

Although additional eligibility reviews may serve a worthwhile and necessary function at VA medical facilities, we are concerned that some VA medical facilities use these additional reviews to limit eligible veterans' access to these services and that this leads VHA away from one standard of care in the provision of purchased home care services.

**Non-compliance
with Waiting List
Requirement**

Six of the eight reviewed VA medical facilities did not follow VHA policy and a 2010 policy reminder from the Deputy Under Secretary for Health Office of Management that required the maintenance of waiting lists. The majority of these VA medical facilities did not maintain required waiting lists in order to mask or constrain the demand for purchased home care services and to limit eligible veterans' access to these services.

In our opinion, veterans who were eligible for purchased home care services under VHA policy were inappropriately deemed ineligible due to the application of the VA medical facilities' local criteria and non-standard review processes. Although skilled care can be provided at a VA medical facility, one benefit of offering veterans purchased home skilled care services is to relieve them of the burden of traveling to a VA medical facility.

Further, in many cases where VA medical facility staff identified other sources to pay for needed homemaker/home aide, respite, or skilled care services, the veterans were referred to the Centers for Medicare and Medicaid Services (CMS) or other resources in the community. However, medical facility staff did not always ensure veterans obtained the needed services, and staff tended not to follow up on referrals to community resources. Regardless of their efforts to assist veterans, VA medical facility

staff were responsible under VHA policy for properly identifying eligible veterans and maintaining waiting lists for purchased home care services.

The waiting list process became irrelevant at the majority of these facilities because veterans who met VHA eligibility criteria, but did not meet the VA medical facilities' local criteria or pass their local review processes for purchased home care services, were not placed on waiting lists. Staff at some VA medical facilities also voiced concerns that the maintenance of waiting lists created a stigma for their medical facilities. Yet, properly maintained waiting lists provide complete information on the unmet purchased home care needs of eligible veterans and help VHA assess its ability to budget for and deliver timely services to veterans.

*Impact of
Restrictive
Local Eligibility
Practices on
Waiting Lists*

The use of restrictive local eligibility criteria and review processes reduced the number of veterans placed on waiting lists. It also, in many cases, allowed VA medical facilities to not maintain waiting lists. In order to estimate the demand for purchased home care services that was not reported on VHA waiting lists, we developed the following benchmarking and estimation process:

- Based on VA's FY 2012 budget, we determined that VA expected to provide purchased home care services to about 5 percent of the veterans enrolled in VA.
- We consulted with GEC and decided to be conservative and to only apply the 5 percent benchmark to those enrolled veterans who were 65 years and older since these veterans were the most likely to need the most services.
- We then applied the 5 percent benchmark to the enrolled 65 or older veteran population at the eight reviewed VA medical facilities and to the nationwide enrolled veteran population to estimate the demand for purchased home care services.
- Lastly, we deducted the number of veterans who had either received the services or were placed on waiting lists to estimate the unmet demand for services not recorded on waiting lists.

Table 2, shows the FY 2012 demand for purchased home care services that was not captured on waiting lists when we applied this benchmarking and estimation process. We limited the estimated number needing services to 5 percent of those over 65-years old.

Table 2

FY 2012 Demand for Purchased Home Care Services Not Captured on VHA Waiting Lists					
Facility	Enrolled Veterans Over 65	Estimated Number Needing Services	Veterans Provided Services	Wait Listed Veterans	Veterans Not Placed on Waiting Lists
1	46,400	2,300	800	0	1,500
2	28,000	1,400	200	0	1,200
3	23,500	1,200	400	40	760
4	22,900	1,100	500	180	420
5	33,600	1,700	1,300	0	400
6	32,500	1,600	1,300	0	300
7	18,200	900	600	0	300
8	15,600	800	600	0	200
Estimated Number of Veterans at the Eight Reviewed Facilities					
	220,700	11,000	5,700	220	5,080
Estimated Number of Veterans Nationally					
	4,100,000	199,000	147,000	3,000	49,000

Source: VHA Support Service Center and VA OIG analysis

Using this benchmark and available VHA data, we estimated in FY 2012 that the 8 reviewed VA medical facilities did not include almost 5,100 veterans who needed purchased home care services on waiting lists. We estimated that nationally, VA did not include a total of 49,000 veterans on waiting lists.

**Reasons for
Limited
Access**

VHA and VA medical facility staff limited veterans’ access to these selected purchased home care services because:

- VA medical facilities reduced the funding for these services to contain the costs of services paid through fee service and to make funding available for higher priorities. These VA medical facilities considered purchased home care services part of their local fee care budgets and made the reduction or containment of fee service costs a rating element in the performance plans of some staff who evaluated patients’ eligibility for purchased home care services.
- Various VA sources contained inaccurate information about the eligibility requirements for purchased skilled care services.

- GEC lacked adequate oversight and monitoring mechanisms for the provision of purchased home care services.

*Funding
Constraints and
Priorities*

Six of the eight VA medical facilities included purchased home care services under their fee program budget even though purchased home care services are not fee program services.² Managers at five of those six medical facilities indicated they needed to reduce or contain fee costs and the use of purchased home care services due to funding constraints.

Further, these VA medical facility managers often did not consider the provision of purchased home care services a high priority compared to other medical services paid through the fee program. Thus, the facilities generally did not adjust their funding to account for increases in ADC targets and the need for these services. Veterans' access to purchased home care services may also have been influenced by the inclusion of a rating element to reduce or contain fee care costs in the performance plans of VA medical facility staff, such as the Chief of GEC, who made eligibility determinations for purchased home care services.

*Inaccurate
Eligibility
Information*

Staff at two VA medical facilities applied more restrictive eligibility criteria for skilled care services than required because of inaccurate eligibility information published by VA and GEC. Staff at these facilities used inaccurate guidance provided in VA's "Veterans' Health Care Benefits Overview" booklet and on GEC's skilled care Web page that stated veterans must be homebound to be eligible for skilled care services. VHA policy does not require veterans to be homebound. Veterans are only required to need short-term services, such as occupational and physical therapy, or long-term skilled care services, such as wound or catheter care. GEC officials confirmed that VA medical facilities need to follow VHA skilled care eligibility requirements and that veterans do not need to be homebound.

*Inadequate
Oversight and
Monitoring*

GEC did not adequately oversee and monitor the provision of homemaker/home aide, respite, and skilled care services. Specifically, GEC issued broad eligibility criteria and established a waiting list requirement but lacked adequate monitors to ensure VA medical facilities uniformly applied the criteria and implemented consistent eligibility review and waiting list processes. GEC was unaware VA medical facilities had implemented additional eligibility criteria and/or supplemental reviews to apply their own interpretations of "medical necessity." While GEC realized that many VISNs and VA medical facilities had not met their ADC targets prior to FY 2012 and were not maintaining waiting lists, GEC did not take appropriate action to address and resolve these problems.

² Purchased home care services are not governed by the regulations of VHA's fee for service program, although the bills are processed through fee service. Unlike fee services, all enrolled veterans who need purchased home care services are eligible for them regardless of their service connection and geographic distance from a VA medical facility.

GEC's inadequate oversight and monitoring enabled VA medical facilities to limit access and mask the demand for homemaker/home aide, respite, and skilled care services. A GEC official indicated that GEC lowered the FY 2012 ADC NIC targets established in VA's approved budget based on its assessment of the VISNs' past performance and veterans' utilization of purchased home care services. GEC did not believe the budgeted ADC targets were achievable and that they needed to be adjusted based on the utilization rate of these services.

GEC lowered the ADC targets established in VA's approved FY 2012 budget for these services from about 25,400 to 24,500 patients, or by an average of 900 veterans a day, with the approval of VHA officials. In our opinion, VHA and GEC made this decision based on the inaccurate assumption that the demand for purchased home care services was low and not suppressed by VA medical facilities. Due to these lower targets:

- Seventy-six million of the original \$676 million in funding that Congress budgeted for homemaker/home aide, respite, and skilled care was redistributed to other VHA healthcare areas because the VISNs purchased home care utilization rate did not support the ADC targets presented in VA's approved budget. Based on the budget Congress approved, VA could have provided just over 199,000 veterans purchased home care services in FY 2012, but the VISNs only received about \$599 million to provide approximately 176,500 patient services, a difference of about 22,500 veterans.
- VHA did not identify VA medical facilities that limited access to purchased home care and did not use waiting lists. The lower ADC targets for the VISNs, as well as other NIC performance monitoring system changes helped 14 of VHA's 21 VISNs' achieve their FY 2012 NIC performance measure.³ If VHA had not lowered the ADC targets for the VISNs, VHA could have come closer to meeting its national NIC ADC target in the FY 2012 Performance Accountability Report.⁴

Weaknesses in GEC's ADC methodology also encouraged VA medical facilities to limit access to these services. Although GEC obtained and published individual ADC data for purchased home care services on a VA Web site for VA medical facilities to review, GEC relied on a general NIC ADC target to monitor the provision of all NIC services, including purchased

³ Other performance monitoring system changes for FY 2012 included eliminating the average workload requirements for homemaker/home aide and allowing the VISNs to meet the NIC performance measure if they closed the gap between their FY 2011 end-of-year performance and FY 2012 ADC targets by 50 percent.

⁴ The Performance Accountability Report is designed to enable VA management, stakeholders, and employees to assess VA's program and financial performance as compared to its goals and to use this information to make necessary improvements. VHA missed its FY 2012 NIC ADC target by just over 8,800 patients.

home care services. GEC did not notice inconsistencies and problems in the VA medical facilities provision of individual NIC services, while its attention was focused on monitoring the overall NIC program.

According to a VHA official who worked with GEC to establish the NIC ADC targets, they developed comprehensive NIC targets for each VISN because it was easier than assigning individual targets to medical facilities or specific purchased home care services. A GEC official also indicated that GEC did not believe they had the capacity to project needs at the individual VA medical facility level.

Even though home based primary care is key to VHA's NIC program, and VA medical facilities high utilization of these services may be justified, GEC's NIC ADC target methodology encouraged VA medical facilities to focus on using this service to meet its NIC target instead of providing needed purchased home care services. When we reviewed data for the eight VA medical facilities, which were all located in different VISNs, we expanded our data analysis to include all of the VA medical facilities in the VISNs.

We noted that 14 of the 57 VA medical facilities in the 8 VISNs relied on home based primary care services to increase their NIC ADC and had not expanded services to address veterans' purchased home care needs. As an example, one VA medical facility that met its FY 2012 NIC ADC target with an ADC of 713 patients provided 514 (72 percent) veterans home based primary care, 147 (21 percent) veterans purchased home care, and 52 (7 percent) veterans other miscellaneous NIC services.

GEC's ADC target methodology allowed VA medical facilities to receive ADC credit for 365 days if a veteran was enrolled in home based primary care and the veteran received at least 10 visits during the year. In contrast, if VA medical facilities provided 10 purchased home care visits in a year, they only received ADC credit for 10 days. The effects of this ADC methodology on NIC workload reporting were noted in a 2004 Government Accountability Office (GAO) report.⁵

GAO reported that the use of enrolled days instead of visits to measure home based primary care did not accurately reflect the amount of services veterans received and inflated workload data compared to other NIC services. Although VHA did not concur with GAO's findings, it agreed to consider different methodologies to assess home based primary care workload. However, VHA still uses enrolled days instead of visits to measure home based primary care workload.

⁵ *More Accurate Measure of Home-Based Primary Care Workload Is Needed* (Report No. GAO-04-913, September 8, 2004).

Finally, our review and analysis of the data for 57 of the VA medical facilities in the 8 different VISNs identified additional inaccuracies and weaknesses in the ADC data used to measure NIC workload. Thirty-eight (67 percent) VA medical facilities, including 6 we visited, had inflated purchased home care ADCs because GEC relied on billing instead of visit data reported in the fee system. This practice meant that the ADC data was inflated if VA medical facility staff improperly entered service visits by hours or as separate line items instead of one line item in the fee billing system.

Example 6

Staff at six VA medical facilities routinely entered the services that agencies provided during a single visit as multiple line items in the fee system. Staff did this because they were unaware that VHA policy required the visit to be recorded as one line item. Consequently, when we compared national VHA purchased home care ADC data and purchased home care visit data, we estimated that 93 of 143 VA medical facilities had overstated their ADC by a total of about 2,100 veterans, thus inflating the ADC for these purchased home care services from 20,000 to 22,100 veterans.

Three VA medical facilities in the reviewed VISNs also reported increases in their NIC purchased home care ADC without increasing veterans' access to these services. An examination of their ADC data showed these facilities increased their ADCs by increasing the frequency of the visits provided to existing enrolled veterans and decreasing or keeping the number of veterans who received services constant. This occurred because senior officials at either the VISN or medical facility directed their facility coordinators to "spread out" the visits of existing veteran patients instead of providing services to more veterans. Consequently, the total purchased home care ADC for these three facilities increased by about 10 (4 percent) veterans, but the number of veterans who received these services decreased by about 390 (14 percent) between FY 2011 and FY 2012.

Effects of Limited Access

VA medical facilities' use of different eligibility criteria, review processes, and the non-use of waiting lists meant that each VA medical facility maintained a different standard of care for the provision of homemaker/home aide, respite, and skilled care services. In addition, VA medical facilities were not collecting information on the demand for these services in a consistent and complete manner. In many instances, VA medical facilities' local eligibility processes restricted the provision of these services and sought to constrain the demand for services.

These practices inadvertently led VHA to lower the ADC targets and to decrease the funding available for homemaker/home aide, respite, and skilled care services in FY 2012 by \$76 million. Additionally, VA medical facilities did not spend about \$99 million (17 percent) of the \$599 million that was allotted for these services, and VHA missed its ADC target by a little under

4,500 veterans in FY 2012. VA medical facility senior officials, such as medical facility directors and chief financial officers redirected \$99 million to address other unidentified VISN and VA medical facility needs. As a result, a total of \$175 million intended for purchased home care services was redirected to other VHA healthcare areas. Appendix D provides VISNs' FY 2012 budget allotments and ADC data.

Conclusion

VHA did not implement one standard of care for the provision of selected purchased home care services because VA medical facilities applied different eligibility criteria and review processes. As a result of these differences, a veteran who is eligible for selected purchased home care services at one VA medical facility may not be eligible for the same services at another facility. VHA lacks adequate oversight and monitoring needed to ensure that it is providing consistent and equitable access to purchased home care services to eligible veterans across the nation.

VHA also cannot meet its ADC targets or overall goal of expanding NIC, including purchased home care services, until VHA and VA medical facilities use budgeted purchased home care service funds for their intended purpose. At a minimum, VHA must ensure its medical facilities consistently apply VHA eligibility criteria and use waiting lists to effectively evaluate the unmet, and possibly unfunded, purchased home care needs of eligible veterans.

Recommendations

1. We recommended the Under Secretary for Health ensure VA medical facilities apply standardized eligibility criteria and ensure purchased home care review processes are not improperly used to limit access to purchased home care services.
2. We recommended the Under Secretary for Health ensure VA medical facilities maintain waiting lists for purchased home care services and assess eligible veterans' unmet needs for services.
3. We recommended the Under Secretary for Health correct eligibility information in VA's "Veterans' Health Care Benefits Overview" booklet and on the Office of Geriatrics and Extended Care's Web site to be consistent with VHA policy and indicate veterans do not have to be homebound to be eligible for purchased skilled care services.
4. We recommended the Under Secretary for Health strengthen non-institutional care program oversight to monitor budgeted and expended funding for purchased home care services and ensure average daily census performance monitoring data is accurate, reliable, and transparent.

5. We recommended the Under Secretary for Health implement effective performance measures for purchased home care services to ensure VA medical facilities do not improperly limit access to services.

**Management
Comments**

The Under Secretary for Health agreed with our recommendations and plans to address our recommendations by June 30, 2014. VHA will initiate a series of actions to strengthen overall purchased home care oversight, the application of national policies and processes, and the use of waiting lists. VHA's planned actions include the following:

- Initiate a 3-part education and oversight process for VISN and facility leadership for purchased home care.
- Conduct audits to identify and review medical facilities' policies to ensure national purchased home care policy is implemented.
- Change the electronic waiting list software and require VHA, VISN, and local officials to monitor and report on VA medical facilities' use of waiting lists.
- Require submission of quarterly waiting list reports and action plans to address unmet needs of veterans on waiting lists longer than 30 days.
- Correct GEC's Web site and the "Veterans' Health Care Benefits Overview" booklet to reflect the appropriate eligibility criteria for purchased home care services.
- Improve the NIC performance measure to ensure the use of visits instead of line items to assess workload and performance.
- Monitor obligations for selected Home and Community Based Services and Purchased Skilled Care Services.
- Include an NIC access performance measure in each of the VISN Directors' FY 2014 performance plans.

Appendix F includes the full action plan, as well as, the Under Secretary's concerns about the OIG's sampling methodology and statistical analysis.

OIG Response

The Under Secretary provided a responsive action plan to address our recommendations. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed. The OIG's response to the Under Secretary's concerns is provided in Appendix G.

Finding 2 VHA Used Ineligible Agencies, Did Not Monitor High-Risk Agencies, and Made Improper Payments

We estimated that VHA annually uses approximately 1,300 ineligible agencies to provide about \$178.7 million in purchased home care services and does not adequately monitor approximately 800 high-risk agencies that provide under \$21.2 million in purchased home care services. We found that 31 of the 200 home care agencies we reviewed lacked required State licenses and/or CMS certifications.

These 31 ineligible agencies provided over 1,100 veterans with \$5 million in homemaker/home aide, respite, and skilled care services. VA medical facility staff should have identified these home care agencies and determined that they were ineligible to provide services. In addition, VA medical facilities did not properly monitor 19 high-risk agencies that provided about \$1.3 million in skilled care services to just over 700 veterans. VHA also made about \$2.6 million in improper payments annually for selected services.

This occurred because GEC and VA medical facilities did not ensure facility staff took appropriate actions to mitigate risks to veterans by properly identifying ineligible agencies and managing agencies determined to be high-risk. Further, home care coordinators did not always ensure providers properly prepared and documented orders for services, and fee staff did not always verify the appropriateness of billings before payments for services were processed.

Without strengthened management of purchased home care services, we estimated over the next 5 years that VHA will use about 1,400 ineligible agencies to provide about \$893.5 million in services, lack adequate monitoring for over 800 high-risk agencies that provide \$106 million in services, and make just over \$13.2 million in improper payments.

Issues with Managing Home Care Agencies

The eight VA medical facilities we reviewed did not consistently ensure the use of eligible agencies and proper monitoring of high-risk agencies.

Table 3 summarizes the purchased home care management issues identified at these eight medical facilities.

Table 3

Summary of Purchased Home Care Management Issues at VA Medical Facilities		
VA Medical Facility	Used Ineligible Agencies	Inadequate Oversight of High-Risk Agencies
1		X
2	X	X
3	X	
4	X	
5		X
6	X	X
7	X	X
8		X
Total	5	6

Source: VHA Central Fee Basis System, CMS Data, and VA OIG analysis

Unlicensed and/or Uncertified Agencies

Five VA medical facilities used 31 ineligible purchased home care agencies that lacked required State licenses and/or CMS certifications. These ineligible agencies provided over 1,100 veterans with \$5 million in homemaker/home aide, respite, and skilled care services during our review period of April 1, 2011 to March 31, 2012. VHA policy requires agencies to have a State license and/or a CMS certification to be eligible to provide purchased home care services. Further, VA medical facilities must obtain exemptions from GEC if they use an ineligible agency. VA medical facilities had not requested and obtained exemptions from GEC to use these 31 ineligible agencies.

VHA requires the use of licensed or certified purchased home care agencies to assure the agencies comply with applicable health and safety standards, meet State qualifications requirements, and comply with Federal and State laws. For States that do not require licenses for services, such as homemaker/home aide, VA medical facilities are required to either use CMS-certified agencies or to obtain an exemption from these requirements from GEC. The following example illustrates how a VA medical facility obtained purchased home care services from ineligible agencies even though certified agencies that provided similar services were available.

Example 7

Staff at one VA medical facility stated they believed it was acceptable to use uncertified agencies if the State did not require a license. They did not, as a rule, check purchased home care agencies for CMS certifications. Consequently, the medical facility used four agencies that were not CMS-certified to provide about \$34,000 in homemaker/home aide and/or skilled care services to five veterans.

VA medical facility home care coordinators either were unaware of VHA oversight and quality monitoring requirements for purchased home care agencies or they misunderstood the requirements. The home care coordinators at the five VA medical facilities that used unlicensed and/or uncertified agencies did not know they routinely needed to monitor agencies to ensure agencies were licensed and/or CMS-certified. Coordinators were also not aware of the requirement to annually report findings and action plans to VA medical facility managers. Monitoring was further lacking because facility managers did not require home care coordinators to submit purchased home care oversight and monitoring reports to them annually.

Facility staff did not know they needed to review agencies' licenses and CMS certifications and to obtain exemptions from GEC when they used ineligible agencies. VHA policy states that VA medical facilities are required to obtain exemptions to use ineligible agencies but it did not include specifics on how the VA medical facilities were to request and obtain the exemptions. This omission in VHA policy contributed to the inaction of VA medical facility staff in requesting exemptions for ineligible agencies.

According to GEC officials, VA medical facilities should have established controls to ensure patients received adequate care, including sufficient monitoring and tracking of patient complaints and care issues. Facility officials should also have conducted an assessment of the impact of using these agencies, in order to obtain exemptions for ineligible agencies. However, these specific requirements were never included in VHA's policy requiring the exemption. Based on the results of our audit, we estimated that VHA annually uses about 1,300 ineligible agencies to provide about \$178.7 million in purchased home care services.

Agencies with Unacceptable CMS Quality Measures

VA medical facility staff at 6 of the reviewed VA medical facilities did not properly monitor 19 high-risk agencies that provided about \$1.3 million in skilled care services to over 700 veterans during our review period. High-risk agencies are agencies that did not perform better than the State average on at least 50 percent of CMS' quality measures.

VHA policy requires VA medical facility staff to monitor CMS-certified agencies if the agencies do not perform better than the State average on at least 50 percent of CMS' quality measures in order to minimize the risk of

quality of care problems. The CMS certification process includes 22 quality measures to assess a home health agency's performance in areas such as:

- Treatment of patients' pain
- Treatment of heart failure patients' symptoms
- Management of pressure/bed sore risks
- Management of patient fall risks
- Frequency of patient admissions to the hospital

If CMS-certified agencies do not meet VHA's quality of care standards, VA medical facility staff are required to develop action plans for those areas where the agencies are deficient and to annually report these issues to VA medical facility management. According to GEC officials, they expected medical facility staff to discuss low scores with the agency's leadership, to determine the reasons for the scores, and to ensure the agency improved its scores. However, the actions the GEC officials outlined were not found in VHA's purchased home care policy.

Staff at five VA medical facilities did not consistently review the agencies' CMS quality measure scores. Further, four medical facilities did not develop action plans for those areas where the agencies were deficient, and report these issues to VA medical facility management. One facility reviewed CMS quality measure scores, but did not prepare action plans for those agencies that had significant deficiencies in their CMS scores. The following example illustrates the potential risks veterans encounter when high-risk agencies are not properly identified and monitored.

Example 8

A home care agency that provided skilled care services to over 400 veterans did not perform better than the State average on at least 50 percent of the CMS' quality measures. The agency only exceeded the State's average scores for 7 (33 percent) of the 21 applicable quality measures. One measure the agency was deficient in involved the assessment of veterans' risk for falls. The State average for this measure was 89 percent, but the agency's score was well below the State average at 68 percent. The VA medical facility lacked action plans for this measure and other measures where the agency was deficient, such as the number of patients admitted to hospitals and improvements in activities of daily living.

We estimated that VHA does not adequately monitor approximately 800 high-risk agencies that annually provide about \$21.2 million in services to veterans.

*Documentation
of Orders for
Services*

From our review of 89 purchased home care invoices totaling over \$900,000 at one VA medical facility, we determined that fee staff at this facility made about \$67,000 in improper payments when they processed 14 purchased home care invoices. We did not identify any significant problems in the documentation of orders at the remaining seven VA medical facilities that we reviewed. Although we only identified this issue at one medical facility, the VA Office of Inspector General (OIG) has noted in a number of its prior reports other problems related to the proper authorization of payments for services provided under VA contracts or VHA's fee program.⁶

VA physicians either did not prepare required orders or prepared orders that lacked specific information about the frequency of the services to be delivered. In some instances, physicians prepared "open-ended" orders that did not include specific information in the initial order and coordinated delivery of the services directly with the agencies. As a result of inadequate ordering procedures, fee staff lacked the documentation needed to verify the appropriateness of 14 billed purchased home care services resulting in nearly \$67,000 in improper payments.

VA policy requires medical staff to document orders for purchased home care services in the patients' medical records, and to include information, such as the type, frequency, and duration of the services to be delivered. VA fee policy requires fee staff to review order information to verify the appropriateness of the billed services. The fee service review is designed to reduce the risk of improper payments, such as duplicate payments, incorrect payments, or payments for unauthorized services. The Improper Payments Elimination and Recovery Act of 2010 calls for all Federal agencies to reduce improper payments where an incorrect amount is paid or the appropriateness of a payment cannot be verified due to insufficient documentation.

The following example illustrates how an improper payment occurred due to insufficient order documentation.

Example 9

A VA physician prepared an order indicating the veteran required skilled services for 60 days, but the order did not specify the frequency or number of visits the veteran was to receive. Fee staff stated that they paid for these services because an order was in the veteran's medical record. However, the lack of information regarding the number of ordered visits prevented the fee staff from

⁶ The most recent reports include *Review of South Texas Veterans Health Care System's Management of Fee Care Funds* (Report No. 11-04359-80, January 10, 2013) and *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* (Report No. 11-02280-23, November 8, 2011).

verifying whether all 12 of the billed visits costing over \$1,500 were necessary and appropriate.

The VA medical facility home care coordinator and fee service supervisor did not consider the absence of orders a problem. They believed there was sufficient information available to pay for the billed services, as long as patients certified that they had received the services. When orders were available, they considered an order sufficient even when the frequency of the service was not identified. The home care coordinator and the fee supervisor did not understand the importance of properly prepared orders in ensuring the availability of sufficient funding, recording the correct financial obligation amount, and verifying billed services to reduce the risk of improper payments and significant budget shortfalls. Based on the results from this medical facility, we projected that VA medical facilities annually make about \$2.6 million in improper payments for purchased home care services due to inadequately documented orders.

**Effect of
Program Risk**

VHA lacks the program controls needed to effectively evaluate and detect problems in the management of purchased home care services. Based on our results, this is a significant program risk. We estimated that if controls are not strengthened over the next 5 years, VHA will purchase about \$893.5 million in services from just under 1,400 ineligible agencies and approximately \$106 million in services from over 800 high-risk agencies without any controls to mitigate the risks to veterans.⁷ VHA will also make about \$13.2 million in improper payments due to the inadequate documentation of orders and inability to verify the need and appropriateness of billed services.

Conclusion

VA medical facilities will not be able to ensure the quality of just under \$1 billion in purchased home care services provided veterans over the next 5 years if they do not strengthen management controls for these services. At present, VA medical facilities lack the monitoring mechanisms and oversight controls to prevent the use of 1,400 ineligible agencies and ensure the adequate monitoring of over 800 high-risk home care agencies.

We considered this a significant program risk because the use of ineligible agencies and inadequate monitoring of high-risk agencies increases the likelihood of veterans experiencing quality of care and service delivery problems. In addition, we found that some VA medical facilities may be prone to making improper payments for purchased home care services over the next 5 years because physicians and other healthcare providers do not

⁷ Funds paid to high-risk agencies were not included in Appendix E regarding potential monetary benefits because VA medical facilities can use these agencies as long as they implement adequate action plans. VA policy does not specifically prohibit the use of these agencies.

consistently prepare adequate orders for services, and fee staff do not consistently review the orders to verify the appropriateness of the billed services.

Recommendations

6. We recommended the Under Secretary for Health implement management controls to ensure VA medical facilities adhere to the Veterans Health Administration's requirements related to the identification and management of ineligible and high-risk purchased home care agencies.
7. We recommended the Under Secretary for Health clarify the Veterans Health Administration's purchased home care policies and provide appropriate VA medical facility staff training on the proper use of eligible purchased home care agencies, exemptions, and the monitoring of high-risk agencies.
8. We recommended the Under Secretary for Health establish effective controls and monitors to ensure providers properly document orders and fee staff properly verify the appropriateness of the services in accordance with VA fee policies before they pay for purchased home care services.

Management Comments

The Under Secretary for Health concurred with our recommendations and plans to address our recommendations by March 30, 2014. VHA plans to issue a memorandum to VA medical facilities to reinforce and clarify quality oversight and monitoring requirements for purchased home care services. VHA will also conduct an audit at 25 VA medical facilities to verify compliance with quality requirements, and conduct additional periodic audits as deemed necessary.

VHA intends to provide management and clinical staff written clarifications and training on the use of home care agencies, appropriate monitoring, and the exemption approval process. A memorandum will reinforce and clarify fee staff's requirements to review and verify that orders contain specific information. Lastly, quarterly reviews will be conducted by facility home care coordinators to ensure the proper documentation of orders.

Although the Under Secretary agreed with our recommendations and is taking action to address these recommendations, the Under Secretary expressed concerns about the OIG's sampling methodology and statistical analysis. Appendix F provides the full text of the Under Secretary's comments.

OIG Response

The Under Secretary provided a responsive action plan to address our recommendations. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed.

Appendix A Background

Purpose of Purchased Home Care Services

In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act, expanding eligibility for purchased home care services to all enrolled veterans for a range of medically necessary services. Prior to the passage of this Act, veterans needed a service-connected disability to be eligible for services. Today, all enrolled veterans are eligible for a comprehensive range of in-home services as identified in VA's healthcare benefits package (Title 38 Code of Federal Regulations, 17.38 (a) (1) (ix)). Veterans of all ages are eligible to use purchased home care services which are an important component of VHA's healthcare service package.

VHA's purchased home care service goals are to ensure that clinically appropriate services are available in veterans' homes to restore or improve veterans' health status, maintain their independence, or to provide comfort-oriented services at the end of their lives. An additional VHA goal is to ensure VA medical facilities' approaches are flexible and innovative with an emphasis on assuring the best resources are accessible to veterans in need of such care. We reviewed skilled care, homemaker/home aide, respite, and hospice services which are described below in more detail.

- Skilled care provides patients short-term or long-term skilled care, such as wound care.
- Homemaker/home aide services assist patients with personal care or other activities of daily living.
- Respite care gives family caregivers and other informal social support workers temporary relief.
- Hospice provides final-stage care and focuses on the comfort of patients with advanced, life-limiting diseases.

Process for Purchased Home Care Services Funding

Under the Veterans Equitable Resource Allocation model, VHA allocates funding to VISNs based on a combination of factors including:

- Number of patients
- Regional variances in labor and contract costs
- High-cost patients
- Education support
- Research support
- Equipment
- Non-recurring maintenance

VHA bases the allotments for purchased home care services on the purchased home care NIC ADC targets established for each VISN and national per diem rates. The 21 VISNs are responsible for monitoring the provision of NIC for VA medical facilities in their region, and establishing ADC targets for their facilities. The VISNs develop a medical care fund allocation for each VA medical facility. The allocation includes an allotment for each provided service.

**Use of CMS
Certified and
State Licensed
Agencies**

As part of GEC's responsibilities, it monitors VA medical facilities' use of purchased home care services and compliance with applicable policies and procedures. VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, requires VA medical facilities to purchase home care services from agencies that are either State licensed or CMS certified. GEC may grant exemptions for agencies that lack a State license or CMS certification based on the recommendation of the VA medical facility's VISN Director.

CMS monitors, inspects, and certifies agencies if they meet several health and safety standards, including multiple detailed requirements related to skilled nursing services, therapy services, social services, and home aide services. In those States that require home care agencies to have licenses, State licensure also attests to the home care agencies' qualifications. State licensure typically indicates the agency is compliant with the State's laws and regulations and the agency's staff meet applicable State professional requirements.

**Oversight of
Agencies'
CMS Quality
Measures**

VHA requires VA medical facilities to integrate a system of oversight and monitoring for purchased home care services into their overall quality management program. The handbook requires staff to routinely measure and analyze quality elements and report issues annually to facility leadership. Subsequently, the handbook requires CMS-certified agencies to perform better than the State average on at least 50 percent of the CMS quality measures. On the CMS Web site, "Home Health Compare" allows VA medical facility staff to obtain information about the agency's performance, to identify opportunities for quality improvement, and to review patients' questions about the agency.

Appendix B Scope and Methodology

Audit Scope

We performed audit work from May 2012 through July 2013. We determined if VHA effectively managed purchased home care services and eligible veterans received appropriate services. The audit reviewed skilled care, homemaker/home aide, respite care, and hospice services provided to patients during the period of April 1, 2011, to March 31, 2012.

We identified the population of these purchased home care patients through payment data maintained in VHA’s Central Fee Basis System. We selected our universe by identifying all VHA patients receiving over \$100 in these purchased home care services during our review period.

We developed a two-stage simple random sample that randomly selected VA medical facilities located in different VISNs. This random sample of VA medical facilities is representative of VHA since the sample included both urban and rural facilities. Similarly, we had no reason to believe that we needed to stratify urban and rural VA medical facilities in our sample. After completion of the first stage, we selected unique patients from each selected VA medical facility who received these purchased home care services during our review period. Appendix C provides more information on the statistical methodology for this audit.

Table 4 provides purchased home care data for the period April 1, 2011, to March 31, 2012, for the eight selected VA medical facilities.

Table 4

VA Medical Facility Purchased Home Care Data				
Medical Facility Location and VISN	Unique Patients Served	Average Daily Census	Agencies Used	Expenditures (in millions)
Miami, FL (VISN 8)	1,229	352	45	\$9.1
Birmingham, AL (VISN 7)	1,454	211	119	\$6.3
Seattle, WA (VISN 20)	995	184	110	\$5.9
Madison, WI (VISN 12)	752	147	101	\$4.1
Hampton, VA (VISN 6)	587	123	91	\$3.1
Amarillo, TX (VISN 18)	873	107	56	\$2.4
Martinsburg, WV (VISN 5)	319	81	65	\$1.9
Detroit, MI (VISN 11)	207	28	51	\$1.2

Source: VHA Central Fee Basis System and VA OIG analysis

We evaluated each VA medical facility's provision and management of purchased home care services, veterans' eligibility for the received services, and agencies' eligibility to provide services. We coordinated with VA OIG's Office of Healthcare Inspections and Office of Investigations to determine if there were any open cases or adverse events related to agencies included in our sample.

Methodology

We interviewed VHA, VISN, and VA medical facility staff to gain an understanding of the controls used to monitor and oversee purchased home care services. During the start of the audit, we discussed with VA and VHA officials our statistical sampling approach. We answered their questions regarding the number and location of sample sites. At that time they concurred with our sampling methodology.

In addition, we also consulted with GEC program officials on the methodology to determine an estimate of patients not placed on waiting lists. GEC officials agreed with the methodology and confirmed that they use the population of all enrolled veterans, not just those who use VA services, to generate projections of future demand for services. Lastly, even though program officials had concurred with our audit methodologies throughout the audit in a number of meetings, it wasn't until the OIG shared its audit results that VA and VHA officials raised concerns about the audit methodologies.

We also reviewed VISN information, such as expenditure, ADC, patient, waiting list data, and NIC meeting minutes. At each of the selected VA medical facilities, we reviewed:

- Budget processes for purchased home care services
- Unique patient counts and ADCs for FY 2012 and prior years
- Local eligibility processes and criteria
- Waiting list documentation
- Patients' medical records
- Purchased home care agency payment documentation

We also conducted interviews with VA medical facility staff to determine if veterans who were eligible for services received needed services or were placed on waiting lists as required by VHA policy. In addition, we reviewed agencies' State licenses and/or CMS certifications to determine if they were eligible and/or met VHA's quality of care standard.

**Fraud
Detection**

We included audit steps to identify potentially fraudulent activities. We developed specific audit steps to determine what management controls, if any, were in place to identify any potentially fraudulent transactions made for the purchased home care services reviewed.

Data Reliability

We relied on computer-processed data in the Central Fee System and VHA Support Service Center and information contained on CMS's "Home Health Compare" Web page. We assessed the reliability of the Central Fee data by tracing 80 patient records and supporting documentation, such as invoices to data provided by the system, and found them to be adequate. Additional data reliability tests included steps to identify any missing data in key fields, calculation errors, and data outside of our period of performance.

We also assessed CMS information by reviewing additional CMS documentation for agencies, such as agency licenses. We also interviewed VA medical facility staff and reviewed relevant waiting list documentation to assess VHA Support Service Center waiting list data. Based on these interviews, tests, and assessments, we concluded the data were sufficiently reliable to meet the audit's objectives.

Government Standards

Our assessment of internal controls focused on those controls related to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence and to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C Statistical Sampling Methodology

Sampling Design

We used a two-stage statistical sample to conduct this audit. The samples were based on a design precision of 7 percent of the estimated dollar amount, a 90 percent confidence level, and an expected error rate of about 10 percent of the total. During the first stage, we randomly selected eight VA medical facilities using a simple random sampling approach within different VISNs that provided purchased home care services during our review period.

It is not feasible to gather information from everyone or every VA medical facility in our population; therefore, using a representative sample (or subset) of that population allowed us to make conclusions about the whole population. Simple random sampling represents the industry standard technique for minimizing sampling error in a study because its strong point comes from randomization. Every VA medical facility in the population had an equal chance of being selected for the sample. The designed confidence level used in this random sample of 8 out of 143 medical facilities is 90 percent. This means that if we repeat this audit several times under the same assumptions, we are confident that the outcome will be the same 90 percent of the time.

For the second stage, we used the Neyman Optimization formula to calculate the sample size. For this stage, patients who had received the selected purchased home care services were randomly selected using a stratified sampling approach based on dollar amount within the VA medical facilities selected in the first stage. We selected 50 unique patients from each of the 8 VA medical facilities. We sampled 400 patients, reviewed 200 home care agencies, and analyzed about 550 billed services totaling about \$4.9 million.

Population

Queries from VHA's Central Fee system disclosed that approximately \$553 million in payments were made to about 13,000 agencies for nearly 127,000 patients during the period of April 1, 2011, to March 31, 2012. To ensure we reviewed high-dollar transactions to address commensurate risks, we removed patients who received less than \$100 in purchased home care services.

Weights

We calculated population estimates using weighted sample data by taking the product of the inverse of probabilities of selection at each stage of sampling. We used WesVar software to calculate population estimates and associated sampling errors. WesVar employs a replication methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design. For the projection of limited access, we used the adjusted Wald method to calculate a 90 percent confidence interval and point estimate because it provides the best coverage for the specified interval when samples are very small.

Projections and Margins of Error

Margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples using the same design for this population, the confidence intervals would differ based on different samples, but would include the true population value 90 percent of the time.

We used the lower limit of the 90 percent confidence intervals to estimate the number of facilities that limited access, used stringent criteria, used supplemental review processes, and/or avoided waiting lists to limit access due to the large number of errors identified in our small sample size. Table 5 shows the total number of errors identified at the eight VA medical facilities and the annualized projections of the number of facilities VA-wide that limited access.

Table 5

Summary of Projections and Margins of Error: Facilities Limiting Access						
Type of Error	Sample Size in Error	Type of Projection	Estimate Number	Margin of Error	90 Percent Confidence Interval	
					Lower Limit	Upper Limit
Limited Access	8	Facilities	129	14	114	143
Supplemental Reviews and/or Stringent Criteria	7	Facilities	125	18	91	143
Avoidance of Waiting Lists	6	Facilities	107	36	63	143

Source: VA OIG analysis

We summarized the errors and VA-wide projections to show the:

- Total number of errors identified at the eight reviewed medical facilities
- Annual projections of the number of ineligible and/or high-risk agencies lacking monitoring and payments made to these agencies lacking monitoring
- Respective ranges between the lower and upper limits of the 90 percent confidence intervals for each projection

Table 6 summarizes the errors and VA-wide projections related to the inadequate management of agencies and documentation of orders.

Table 6

Summary of Projections and Margins of Error: Inadequate Management of Agencies and Documentation of Orders						
Type of Error	Sample Size in Error	Type of Projection	Estimate Number (\$ in millions)	Margin of Error (\$ in millions)	90 Percent Confidence Interval	
					Lower Limit (\$ in millions)	Upper Limit (\$ in millions)
Ineligible Agencies	31	Agencies	1,311	499	811	1,810
		Payment Amount	\$178.7	\$90.2	\$88.5	\$268.9
High-Risk Agencies Lacking Monitoring	19	Agencies	770	347	423	1,116
		Payment Amount	\$21.2	\$8.5	\$12.7	\$29.7
Patient Billings With Improper Payments	14	Payment Amount	\$7.1	\$4.4	\$2.6	\$11.5

Source: VA OIG analysis

We used the midpoint of the 90 percent confidence interval for the number of ineligible and high-risk agencies lacking monitoring. For the inadequate documentation of orders, we used the lower limit of the 90 percent confidence interval due to the low number of errors identified in our sample and because of the large variability.

We used an exponential smoothing forecasting technique to project the number of ineligible agencies VHA will use and/or high-risk agencies that will lack adequate monitoring over the next 5 years if management controls are not strengthened. The Microsoft Excel formula predicts a value that is based on the forecast for the prior period, adjusted for the error in that prior forecast. We also multiplied the payment amounts in Table 6 by 5 years to project the potential payments made to these ineligible and/or high-risk agencies and possible improper payments for the selected purchased home care services. The 5-year projections follow.

- Approximately, 1,400 ineligible agencies will provide services at a cost of about \$893.5 million (\$178.7 million × 5 years).

- Approximately, 800 high-risk agencies will provide \$106 million (21.2 million \times 5 years) in services without adequate oversight.
- Improper payments for the selected purchased home care services will increase to about \$13.2 million (\$2.6 million \times 5 years). Due to rounding, the product of the improper payments multiplied by 5 years does not exactly equal \$13.2 million.

Appendix D FY 2012 VISN Funding Allotments and Average Daily Census Data for Selected Purchased Home Care Services

Table 7 compares the allotments and expenditures for purchased home care services by VISN in FY 2012. The VISNs are presented in order based on how they performed relative to their ADC targets as shown in the last column on the right. In FY 2012, VHA allotted the VISNs about \$599 million for homemaker/home aide, respite, and skilled care services.

However, VA facilities spent just under \$501 million or 17 percent less than the allotted amount and missed their combined VISN ADC target of about 24,500 patients for these services by about 4,500 patients. Sixteen VISNs did not spend the amount allotted for these services and did not meet their ADC targets. The VISN budget allocation column represents the estimated amount of general medical services funding each VISN was expected to spend to meet the performance measure (ADC target) assigned by GEC.

Table 7. FY 2012 VISN Budget and ADC Data for Selected Purchased Home Care Services Excluding Hospice						
VISN	VISN Budget Allocations	VISN Expenditures	Difference Between Budget and Expenditures	ADC Target (rounded)	ADC Performance (adjusted)	Difference Between ADC Performance and Target
16: Ridgeland, MS	\$49,504,738	\$24,654,727	-\$24,850,011	2,021	1,126	-895
21: Mare Island, CA	\$25,351,017	\$18,261,224	-\$7,089,793	1,035	539	-496
04: Pittsburgh, PA	\$37,828,625	\$24,101,442	-\$13,727,183	1,544	1,077	-468
11: Ann Arbor, MI	\$27,250,859	\$17,351,223	-\$9,899,636	1,113	674	-439
22: Long Beach, CA	\$30,615,163	\$30,171,097	-\$444,065	1,250	816	-434
01: Bedford, MA	\$29,022,066	\$21,542,966	-\$7,479,100	1,185	758	-427
20: Vancouver, WA	\$25,944,718	\$21,909,313	-\$4,035,404	1,059	708	-351
09: Nashville, TN	\$27,428,969	\$19,524,782	-\$7,904,187	1,120	807	-313
17: Arlington, TX	\$26,310,833	\$18,677,991	-\$7,632,842	1,074	853	-221
03: Bronx, NY	\$27,339,914	\$22,718,751	-\$4,621,164	1,116	941	-175
05: Linthicum, MD	\$15,277,896	\$14,474,130	-\$803,766	624	465	-159
02: Albany, NY	\$14,120,180	\$7,106,533	-\$7,013,647	577	422	-155
08: Bay Pines, FL	\$56,183,870	\$49,865,686	-\$6,318,184	2,294	2,141	-153
07: Duluth, GA	\$35,325,188	\$26,467,077	-\$8,858,110	1,442	1,291	-152
18: Mesa, AZ	\$24,777,106	\$22,989,145	-\$1,787,962	1,012	867	-144
15: Kansas City, MO	\$23,372,015	\$17,529,006	-\$5,843,009	954	870	-84
12: Hines, IL	\$25,054,167	\$25,743,801	\$689,634	1,023	988	-35
19: Glendale, CO	\$17,157,948	\$18,784,318	\$1,626,370	701	744	43
06: Durham, NC	\$31,020,858	\$31,515,680	\$494,822	1,267	1,426	160
23: Minneapolis, MN	\$28,458,050	\$39,313,798	\$10,855,748	1,162	1,346	185
10 Cincinnati, OH	\$21,957,028	\$27,862,729	\$5,905,701	896	1,149	253
Total	\$599,301,210	\$500,565,421	\$98,735,789	24,466	20,009	-4,457

Source: VHA Support Service Center, VHA Central Fee Basis System, and VA OIG analysis

Appendix E Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
6	Strengthen controls over purchased homecare services to reduce the use of ineligible agencies over the next 5 years.	\$893.5 million	\$0
8	Strengthen controls over the preparation of orders and verification of billed purchased homecare services over the next 5 years.	\$0	13.2 million
	Total⁸	\$893.5 million	\$13.2million⁹

⁸ These amounts are not a “cost savings” since these vital services are still needed in the future.

⁹ These questioned costs are projected from the findings identified at one of the eight VA medical facilities we reviewed.

Appendix F Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 23, 2013

From: Under Secretary for Health (10)

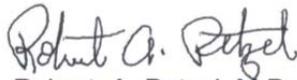
Subj: VA Office of Inspector General (OIG) Draft Report, Veterans Health Administration, Audit of Selected Non-Institutional Purchased Home Care Services (VAIQ 7392065)

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

1. Thank you for the opportunity to review the draft report detailing the Office of Inspector General's (OIG) audit of eight Veterans Affairs (VA) medical centers. I concur with OIG's recommendations. I have strong plans in place to address those recommendations, and will provide action plans to improve the provision of non-institutional purchased home care services to Veterans. However, I have concerns about some of the estimates and projections presented in this report.
2. I am concerned that this report does not account for the significant variability in access to local home care agencies. The report assumes that because Veterans Health Administration (VHA) has a national policy on purchasing home care services, all facilities have the same access to purchased home care service providers in their local community. Yet, each facility is limited to only those agencies that serve the patient's locale (home), and then to only those services provided by that agency. In urban areas multiple agencies may provide comprehensive services, while in rural areas, there may be only one agency that provides limited services depending on the skill set of their workforce.
3. I concur with OIG that some funds were used to pay ineligible home care agencies, and VHA is working to strengthen our performance in this area. However, I do not agree with OIG's national estimate of the number of VA medical centers potentially limiting access to services (114), the projected potential use of ineligible agencies (1,300), or the projection that VA could pay \$893.5 million to ineligible agencies over 5 years. These estimates and projection are based on data generated by simple random, as opposed to stratified, sampling methodology, and thus do not accurately represent the complexity of non-institutional purchased home care for Veterans nation-wide. Additionally, they do not contain the level of reliability needed for national health care decision making.
4. OIG may not be aware that many Veterans administratively enroll at their local VA medical centers just in case they might want to supplement their private care with VA services in the future. Only a subset of enrolled Veterans elect to use

VA clinicians for their care. Therefore I do not concur with the national estimate in the report that 49,000 Veterans who should have been wait listed for purchased home and community based services (HCBS) were not wait listed, as reported in Table 2. VHA has developed improved mechanisms to assure that Veterans who are enrolled with VA for health care either receive purchased home health care for their needs or are placed on a wait list which will be tracked.

5. OIG correctly identified improper payments at one facility. This will be addressed, and appropriate personnel at all other facilities will receive clear and comprehensive guidance on proper documentation of orders for these services. I am pleased that OIG did not identify any significant problems in the documentation of orders at the other seven facilities they audited. However I do not concur with the 5-year projection of \$13.2 million in improper payments. This figure is based on actual improper payments of \$67,000 at the one problematic facility. I believe there is insufficient justification to support the projection beyond the actual finding, particularly in light of my aforementioned concerns about the facility sampling methodology.
6. I am concerned with Table 7 of Appendix D, which shows "VISN Budget Allocations". Funds for Purchased HCBS programs are sent to the VISNs as General Purpose Funds and not specifically reserved for Purchased HCBS programs.
7. If you have any questions, please contact Karen M. Rasmussen, M.D., Acting Director, Management Review Service (10AR) via telephone at (202) 461-6643.


Robert A. Petzel, M.D.

Attachment

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

**OIG Draft Report, Audit of Selected Non-Institutional Purchased Home Care Services
(VAIQ 7392065)**

Date of Draft Report: August 1, 2013

<u>Recommendations/ Actions</u>	<u>Status</u>	<u>Completion Date</u>
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Recommendation 1: We recommended the Under Secretary for Health ensure VA medical facilities apply standardized eligibility criteria and ensure purchased home care review processes are not improperly used to limit access to purchase home care services.

VHA Comments

Concur

1) The Offices of the Deputy Under Secretary for Health for Policy and Services (DUSHPS, 10P) and Deputy Under Secretary for Health for Operations and Management (DUSHOM, 10N) have initiated a three-part education and oversight plan.

- a) The Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Clinical Operations (10NC) is responsible for presenting to Veterans Integrated Service Network (VISN) and facility leadership a review of national policy on eligibility criteria for Purchased Home and Community Based Services (HCBS) (VHA Handbook 1140.06).
- b) 10NC is responsible for instructing facilities to replace any more stringent local policies with National policy to ensure a standardized process is in place.
- c) The Office of the ADUSH for Health for Patient Care Services (10P4) and Geriatrics and Extended Care Services (10P4G) in collaboration with 10NC and the Office of Geriatrics and Extended Care Operations (10NC4) will conduct education with clinical program leadership at VISN and facility level on the national call for each program.

In process October 31, 2013

2) 10NC4 will conduct an audit of facility policies for Purchased HCBS from a sample of Veterans Affairs Medical Centers (VAMC). VHA will begin the audit Quarter 1 of Fiscal Year 2014 to ensure that national policy is implemented.

In process March 31, 2014

3) 10NC4 will conduct phone audits to identify and report on local criteria for Purchased Care programs. The audit will look at a sample of facilities in Quarter 1 and Quarter 2 of Fiscal Year 2014. VHA will then expand the phone audit or transition the audit process to the Veterans Integrated Service Networks (VISN).

In process March 31, 2014

To close this action plan, VHA will provide:

1. Documentation that the presentation of the review of national policy and eligibility criteria was held, and when.
2. Documentation of VHA's direction to facilities to align local policies with national policy.
3. Schedule of educational calls and one post call meeting note referencing the call discussions, to include a list of attendees.
4. Summary of results of the audit of facility policies for two quarters
5. Summary of results of the phone audit on eligibility criteria for two quarters.

Recommendation 2: We recommended the Under Secretary for Health ensure VA medical facilities maintain waiting lists for purchased home care services and assess eligible veterans' unmet needs for services.

VHA Comments

Concur

1) VHA has initiated changes in the Electronic Waiting List (EWL) software package to more accurately account for the various Purchased Home and Community Based Services (HCBS) programs. Once the software changes are complete, 10NC4 will provide education in written form and via scheduled conference calls with all HCBS management and clinical groups. 10NC4 will require that electronic wait lists be monitored at the local, VISN, and Veterans Affairs Central Office (VACO) level. EWL reports from VISNs will be submitted to 10NC4 on a quarterly basis beginning Quarter 1 of FY 2014, with action plans required as appropriate to address unmet needs for Veterans who are on the EWL greater than 30 days. If VISN performance on Non-Institutional Care (NIC) Performance Measure falls below 80 percent, an audit will be triggered.

In process March 31, 2014

To close this action plan VHA will provide:

1. Documentation of the written and conference call education provided to the field.
2. The EWL monitoring report from a sample of facilities, all VISNs, and VACO for two quarters
3. The Quarter 1 FY 2014 and Quarter 2 FY 2014 reports from VISN to VACO on EWLs.
4. The remediation plan from a facility or facilities that has/have Veterans waiting for services greater than 30 days.
5. Number of facilities that will be audited due to NIC performance below 80 percent.

Recommendation 3: We recommended the Under Secretary for Health correct eligibility information in VA's "Veterans' Health Care Benefits Overview" booklet and on the

Office of Geriatrics and Extended Care's Web site to be consistent with VHA policy and indicate veterans do not have to be homebound to be eligible for purchased skilled care services.

VHA Comments

Concur

1) The Geriatrics and Extended Care Website will be corrected to reflect the appropriate clinical criteria for admission to Home and Community Based Services (HCBS).

In process October 30, 2013

2) VHA's Chief Business Office (CBO) will incorporate the correction into the next publication of The Veteran's Health Care Benefits Overview booklet, which is scheduled to be printed in late September 2013.

In process November 30, 2013

To close this action plan VHA will provide:

1. The web link to the Geriatrics and Extended Care Website that contains the appropriate clinical criteria for admission to HCBS.
2. A copy of (or web link to) the final approved section in the Veterans' Health Care Benefits Overview booklet that contains corrected information. Closure does not depend on waiting for final publication – but rather that the language has been approved for final publication.

Recommendation 4: We recommended the Under Secretary for Health strengthen non-institutional care program oversight to monitor budgeted and expended funding for purchased home care services and ensure average daily census performance monitoring data is accurate, reliable, and transparent.

VHA Comments

Concur

1) VHA has initiated improvements in the Access to Non-Institutional Care (NIC) performance measure. Workload for Purchased Home and Community Based Services (HCBS) will use visits instead of line items. 10P4G will generate monthly reports on workload and 10NC4 will require written plans and updates from VISNs which are performing below the 92 percent level. This change will positively affect the accuracy, reliability and transparency of reported workload.

In process December 31, 2013

2) 10P4G will monitor obligations in selected Home and Community Based Services (HCBS) programs. Each VISN and VAMC will have a per census per month obligation target for Homemaker/Home Health Aide (H/HHA), Community Adult Day Health Care (CADHC), Home Respite, and Veteran Directed HCBS. 10P4G will generate monthly reports on

obligations and 10NC4 will determine the requirement for written plans and updates from VISNs that are performing below the 80 percent level of the obligation targets.

In process December 31, 2013

3) 10P4G will monitor workload and obligations in Purchased Skilled Home Care. VHA will enhance its monthly workload and obligations reports to establish appropriate baselines. Once the baseline has been determined, 10NC4 will require written plans and updates from VISNs that are performing below the 92 percent level.

In process May 31, 2014

To close this action plan, VHA will provide:

1. The Quarter 2 FY 2014 monthly report on workload and the written plan from any VISN(s) that is/are performing below the 92 percent of the NIC Access Performance Measure.
2. The March 2014 monthly report on obligations and a list of VISNs required to provide written plans and updates (i.e., VISNs that are performing below 80 percent of the obligation targets).
3. The March 2014 monthly report on obligations for Purchased Skilled Home Care and a list of VISNs required to provide written plans and updates (i.e., VISNs that are performing below 92 percent of the NIC Access Performance Measure).

Recommendation 5: We recommended the Under Secretary for Health implement effective performance measures for purchased home care services to ensure VA medical facilities do not improperly limit access to services.

VHA Comments

Concur

- 1) Access to Non-Institutional Care (NIC) performance measure will be written into all Network Director Performance Plans as a mandatory measure for Fiscal Year 2014.

In process March 31, 2014

2) 10P4G will develop an access performance measure which will include VISN recommended ranges for personal care services in the aggregate (combining Homemaker/Home Health Aide (H/HHA), Community Adult Day Health Care (CADHC), Home Respite, and Veteran Directed HCBS).

In process March 31, 2014

3) The Office of the DUSHOM (10N) will institute an access performance measure which will include VISN recommended ranges for personal care services in the aggregate (combining H/HHA, CADHC, home respite, and Veteran Directed HCBS).

In process June 30, 2014

To close this action plan, VHA will provide:

1. Documentation from the Office of the DUSHOM (10N) certifying that this measure is in each Network Director's Performance Plan.
2. Documentation of the Performance Measure in VHA's technical manual

Recommendation 6: We recommended the Under Secretary for Health implement management controls to ensure VA medical facilities adhere to the Veterans Health Administration's requirements related to the identification and management of ineligible and high-risk purchased home care agencies.

VHA Comments

Concur

1) 10P4G will prepare a memorandum for the DUSHOM (10N) to issue to the field reinforcing and clarifying requirements for Quality Oversight and Monitoring of Purchased Home Care Services. Exemptions may be granted by Geriatrics and Extended Care (10P4G and 10NC4, jointly) on the cost of maximum care, licensure, or accreditation of community services on the recommendation of the VISN Director.

In process January 10, 2014

2) VACO will conduct an audit of 25 facilities in Quarter 1 of Fiscal Year 2014, to verify compliance with requirements for Quality Oversight and Monitoring of Purchased Home Care Services. Validation of waivers will be requested for agencies not meeting eligibility criteria outlined in VHA policy. Additional periodic audits may be performed in the future as deemed necessary.

In process January 31, 2014

To close this action plan, VHA will provide:

1. An electronic copy of the memo from the DUSHOM (10N).
2. A summary of the audit results for one quarter.

Recommendation 7: We recommended the Under Secretary for Health clarify the Veterans Health Administration's purchased home care policies and provide appropriate VA medical facility staff training on the proper use of eligible purchased home care agencies, exemptions, and the monitoring of high-risk agencies.

VHA Comments

Concur

1) VHA will provide written clarifications of policy regarding the use of home care agencies, appropriate monitoring, and the exception approval process. In addition, VHA will hold training on this subject across management and clinical staff levels.

In process March 30, 2014

To close this action plan, VHA will:

1. Provide the written policy clarification.
2. Provide the dates of planned training scheduled for VHA management and clinical staff, with one set of post educational notes to include attendees.

Recommendation 8: We recommended the Under Secretary for Health establish effective controls and monitors to ensure providers properly document orders and fee staff properly verifies the appropriateness of the services in accordance with VA fee policies before they pay for purchased home care services.

VHA Comments

Concur

1) A memo will be issued from the DUSHOM (10N) reinforcing and clarifying the requirements for Non-VA Medical Care Office (fee) staff at each VAMC to review and verify the documentation includes an order for purchased home care services, type of service, frequency, and duration of service to be delivered.

In process October 31, 2013

2) The homecare coordinator will conduct quarterly reviews to ensure that orders are properly documented, and report periodically to the VISN.

In process January 10, 2014

To close this action plan, VHA will provide:

1. The memo issued by the DUSHOM (10N).
2. Will submit one quarter of review/results ensuring that orders are properly documented.

Veterans Health Administration
September 2013

Appendix G Office of Inspector General Response to the Under Secretary's Comments

The Under Secretary for Health raised a number of concerns about our estimates and statistical projections after reviewing our draft report on non-institutional purchased home care services. Specifically, the Under Secretary states that:

- The report does not account for the possible variability in access to local home care agencies and services.
- He does not agree with the report's projections of the number of VA medical facilities limiting access, the number of ineligible agencies, and the amount paid to ineligible agencies because he states that OIG's use of random sampling does not adequately represent the complexity of purchased home care for veterans nation-wide and does not yield reliable results for decision making.
- He non-concurs with our estimate that 49,000 veterans have not been placed on waiting lists for purchased home care services because only a subset of enrolled veterans actually use VA services.
- The OIG is not justified in its projection of the improper payments it identified at one of the eight reviewed VA medical facilities.
- The "VISN Budget Allocations" provided in Table 7 of Appendix D could be misconstrued as reserved purchased home care services funding and not general purpose funds that can be used to provide any medical service.

These concerns were not raised by VA or VHA program staff at the start of the audit, nor during the course of the audit, when the OIG briefed them on its statistical sampling approach and results and the development of an estimate of the number of veterans not placed on waiting lists. We also had a number of meetings with VA and VHA officials since the end of the audit to discuss our statistical sampling methodology and our waiting list estimate. At this time, the OIG provides the following response to address the Under Secretary's specific concerns:

Accounting for Potential Variability in Veterans' Access. The OIG ensured its audit adequately accounted for possible variations in veterans' access to local home care agencies through its use of statistical sampling. Statistical samples are objective and unbiased, and yield audit results that are representative of the entire population. Given this premise, any condition or characteristic identified at the selected eight VA medical facilities would be representative of those found in VA's population of medical facilities. Although variability in access to home care agencies could, as the Under Secretary noted, limit veterans access to home care services, this was not a factor at the eight statistically selected VA medical facilities we reviewed.

The eight reviewed VA medical facilities had home care agencies available to provide needed purchased home care services regardless of whether the patients lived in an urban or rural area. The reviewed VA medical facilities limited access to purchased home care services due to funding constraints, the desire to contain fee program costs, the promulgation of inaccurate eligibility criteria, and the absence of adequate program oversight. For these reasons, we do not consider the lack of available home care agencies to serve patients a salient factor in the current discussion. Further, given the high error rate of VA medical facilities (100 percent) that limited access in our sample, the OIG used the lower limit of 114 VA medical facilities instead of 143 facilities to account for potential unknowns in the population.

Use of Random Sampling. The Under Secretary does not agree with our projections because he contends that a random sample does not accurately represent the complexity of purchased home care and it is not reliable for national decision making. As the OIG stated previously, it believes that randomly selected sites provide an accurate representation of purchased home care services in VA because the statistically selected sites are representative of VA's universe of medical facilities, their patient populations, and the conditions under which the facilities operate. The statistical projections on Appendix C show the confidence level for our estimates, thus showing reliability of our results. The 8 VA medical facilities we visited were located in 8 of VHA's 21 VISNs, represented VA medical facilities in urban and rural areas, and represented 3 of VHA's 5 facility complexity levels.¹⁰

Similarly, the OIG disagrees with the Under Secretary's assertion that a stratified random sampling approach would have yielded more accurate results than a random sample. This audit was performed to assess VA medical facilities' implementation of VHA patient eligibility and waiting list policies and compliance with VHA home care agency review and monitoring requirements. Simple random sampling increased the accuracy and precision of our projections because each facility had an equal chance of being selected in our test to determine whether or not VA medical facilities across the country properly applied VHA purchased home care policies. In contrast, stratified sampling would require the sampling of various facility groupings using characteristics that may or may not have any bearing on the level of compliance with VHA policy. Further, our review results for the eight VA medical facilities demonstrated that stratified sampling was not necessary in this instance. Regardless of geographic location, differences in facility complexity level, and possible variations in home care agency availability, all eight of the reviewed VA medical facilities limited access, to some degree, due to internal factors such as the need to control fee program

¹⁰ VHA's Office of Quality and Safety defines complexity as characteristics of the patient population, clinical services offered (cardiac surgery is considered more complex than throat surgery), educational and research missions, and administrative complexities.

costs, the need to make funds available for higher priorities, or a reliance on incorrect eligibility information. See Appendix C for specific information on our statistical sampling methodology.

Estimate of Patients Not Placed on Waiting Lists. The Under Secretary for Health disagrees with the OIG's estimate that 49,000 veterans were not placed on waiting lists because our estimate used the number of enrolled veterans to determine the demand for services and he states that only a subset of enrolled veterans actually uses VA services. While the Under Secretary for Health raises a real life situation that merits some consideration, we affirm our use of the enrolled veteran population to prepare our estimate. GEC officials who we consulted with during the course of the audit agreed with our methodology and confirmed that use of the enrolled veteran population was consistent with the current standards and methodologies VHA uses to forecast the demand, develop the budget, and allocate funds and resources for purchased home care services. GEC obtains data from the VA Enrollee Health Care Projection Model to forecast the demand for purchased care services and to prepare VA's annual budget requests for purchased home care services. This model uses the population of all enrolled veterans, not just those who use VA services, to generate its projections.

Improper Payments Projected From Results of One VA Medical Facility. The OIG understands the Under Secretary's concerns regarding the national projection of \$13.2 million in improper payments based on the results from one VA medical facility. The OIG took this into consideration and used the lower limit projection of \$13.2 million instead of the middle estimate of \$35.5 million to determine the number of improper payments VHA will make over the next 5 years. Further, the OIG asserts that under the principles of statistical sampling, this is a valid projection. The fundamental premise behind statistical sampling is that if one objectively calculates a sample size and selects a small subset of items to test, the results of the evaluation can be used to make an inference about the larger target population. Further, in probability sampling, all items must have a known chance of selection and the items must be selected through a random procedure in order to avoid selection bias. Using probability sampling principles, the OIG applied a statistical formula to the improper payments identified at one VA medical facility to estimate values for the entire population and to calculate margins of error for estimates to the entire population. As a result, the OIG contends the projection is valid and that action is needed across VA to try to prevent similar improper payments from occurring at other VA medical facilities because the errors, even at only one VA medical facility in our sample are representative of additional errors in the remaining population of VA medical facilities. Appendix C has more information on our statistical sampling methodology, which describes how our projections for two-stage sampling approach were derived.

VISN Budget Allocations. The OIG notes the Under Secretary’s concern and provided clarification for the “VISN Budget Allocations” data in Appendix D.

Appendix H Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Janet Mah, Director Edesha Basa Lee Giesbrecht Milan Gokaldas Andrea Lui Kelly Perry Corina Riba Daniel Rico Nelvy Viguera Butler
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Appendix I Report Distribution

VA Distribution

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Non-VA Distribution

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