



# Office of Inspector General

## AUDIT OF DEPARTMENT OF VETERANS AFFAIRS FINANCIAL AND MANAGEMENT OVERSIGHT OF HOME IMPROVEMENT AND STRUCTURAL ALTERATIONS (HISA) PROGRAM

*VA should define allowable HISA services, better identify eligible veterans for the program, and strengthen financial management.*

**Report No.: 7R5-D05-006**  
**Date: November 18, 1996**



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington DC 20420**

**Memorandum to the Under Secretary for Health (10)**

**Audit of Financial and Management Oversight of the Home Improvement and Structural Alterations (HISA) Program**

1. The audit was initiated at your request to evaluate the financial and management oversight of the HISA program and determine whether the program is prudently using its funds. The HISA program was established in October 1976 to assist veterans who needed a home improvement or structural alteration to provide accessibility to the home or ensure continuation of treatment in the home, rather than in a hospital or nursing home.
2. HISA benefits are paid from the Medical Care Appropriation. Each entitled veteran has a lifetime benefit limitation. The HISA benefit limitations increased in 1992 to \$4,100 for service-connected veterans and \$1,200 for nonservice-connected veterans. The increases were made retroactive to 1990. HISA program costs have increased over the last 5 years—from \$1.9 million in Fiscal Year (FY) 1991 to \$4.1 million projected for FY 1996. On September 29, 1995, administrative responsibilities for the HISA program were transferred from Medical Administration Service to Prosthetic and Sensory Aids Service (PSAS). Our audit included HISA payments authorized during the period October 1, 1990 through March 31, 1996.
3. We evaluated the effectiveness of procedures followed by Department of Veterans Affairs (VA) medical center (VAMC) staff to ensure that HISA services paid for were allowable under VA criteria and were properly approved and accomplished. We also assessed the level of patient participation in the program to determine whether it was appropriate, and we evaluated whether financial controls over the program ensured that payments were proper and that costs were accurately reported and monitored. We conducted audits at six VAMCs and requested selected information from all VAMCs through the use of a questionnaire. We worked closely with the Director, PSAS, and his staff during the audit to formulate needed changes to the program. Since HISA responsibilities had only recently been transferred to PSAS, these officials had not yet had the opportunity to review the program. As a result, they joined us in a cooperative effort to improve the program.

4. The HISA program is important to successful and efficient treatment of eligible veterans. The HISA program was accomplishing its intended purpose of allowing veterans better access to their homes in order to live at home while continuing treatment. The program was popular among the veterans that we interviewed. The transfer of program responsibility to PSAS may result in better service to veterans eligible for the program because HISA program duties and responsibilities (e.g., clinical evaluation, eligibility counseling, contracting, etc.) are closely related to those of PSAS. Also, in many cases, the veterans applying for HISA benefits have had previous interactions with PSAS staff. Thus, for the most part, the staff already have knowledge of the veterans' conditions. We recommended improvements in two areas and identified a third area that needs management attention. We believe these improvements are needed to ensure program funds are prudently used.

5. We found payments for projects or portions of projects that did not provide improved accessibility to the veterans' homes or ensure continuation of treatment in the home. Also, some projects should have been paid from Prosthetic funds rather than from HISA grants, and other HISA payments were made for improvements that duplicated those provided by the Specially Adapted Housing program. As a result, some veterans received inappropriate home improvements totaling \$47,520, while others had their lifetime HISA benefits used unnecessarily, thereby denying them use of these funds for appropriate home improvements at a later time when more extensive alterations may be needed.

6. Through our site visits and the responses to our questionnaire, we found that staff at 10 VAMCs did not actively identify veterans for the HISA program. The staff placed a low priority on the HISA program and, instead, used most of their discretionary funds for other purposes. Also, staff at four of the six VAMCs we visited had not made required retroactive payments to veterans when the lifetime limitations increased in 1992. Based on this review, there may be many other medical centers that have not made the retroactive payments. In addition, program funds were not adequately controlled at any of the six VAMCs visited. As a result, some veterans, including some having highly visible disabilities, were not aware that they were entitled to HISA benefits. Others did not receive retroactive compensations totaling at least \$14,400 when the benefits increased, and some exceeded their lifetime HISA limits. Also, controls were not sufficient to identify prior HISA payments to veterans or to ensure that funds which were not needed by the veterans were timely deobligated for other use.

7. The method of funding the HISA program was an area of concern to PSAS officials. The HISA program competes with other medical programs for available medical care dollars. As a result, some medical centers did not provide much funding for the HISA program, and other medical centers, particularly those with larger budgets, spent significant amounts for the program. PSAS officials preferred centralized control

of funding, instead of the current local funding, because they believed they could ensure that adequate funds were spent on the HISA program. We believe that the issue of central control of HISA funding addresses a larger policy issue—priority of use of medical care funds. In the legislation for the HISA program, Congress used the term “*may* furnish such home health services.” In implementing the legislation for the HISA program, we believe that Veterans Health Administration (VHA) officials need to determine to what additional degree, if any, this program should receive priority funding considerations. Because we believe this is a policy issue, we did not make a recommendation concerning how the HISA program should be funded.

8. We made recommendations to improve the definition of eligible projects/services and to improve financial management of the program. You concurred with the recommendations and the estimated monetary efficiencies, and you prepared acceptable implementation plans. We consider all audit issues resolved and will follow up on the implementation plans until they are completed.

For the Assistant Inspector General for Auditing

*[Signed]*

WILLIAM D. MILLER

Director, Kansas City Operations Division

## **TABLE OF CONTENTS**

	<b><u>Page</u></b>
<b>Memorandum to the Under Secretary for Health (10)</b> .....	<b>i</b>
<b>RESULTS AND RECOMMENDATIONS</b>	
1. Central Office Guidance Is Needed To Define and Clarify Allowable Home Improvement and Structural Alterations (HISA) Services .....	1
Recommendation 1 .....	5
2. Improved Financial Management Is Needed To Ensure Program Funds Are Efficiently Used and Properly Monitored .....	7
Recommendation 2 .....	11
3. Concern Over Funding the HISA Program .....	14
<b>APPENDIXES</b>	
<b>I OBJECTIVES, SCOPE AND METHODOLOGY</b> .....	<b>15</b>
<b>II BACKGROUND</b> .....	<b>17</b>
<b>III DETAILS OF AUDIT</b> .....	<b>19</b>
Other Projects That Did Not Improve Accessibility .....	19
Other Causes For Approval of Projects That Were Not Medically Necessary .....	20
Description of Sites Audited .....	22

## **TABLE OF CONTENTS (Continued)**

	<b><u>Page</u></b>
<b>IV</b> MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS .....	23
<b>V</b> MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH.....	25
<b>VI</b> FINAL REPORT DISTRIBUTION .....	31

## **RESULTS AND RECOMMENDATIONS**

### **1. Central Office Guidance Is Needed To Define and Clarify Allowable Home Improvement and Structural Alterations (HISA) Services**

Congress authorized home improvements and structural alterations for eligible disabled veterans that aid in providing access to the home or essential lavatory and sanitary facilities, or ensure the continuation of treatment in the home. We found some HISA payments for projects or portions of projects that did not provide improved accessibility to the home or ensure continuation of treatment. Also, we found projects that should have or could have been paid from Prosthetic and Sensory Aids Service (PSAS) funds or that duplicated improvements provided by the Specially Adapted Housing (SAH) program. These conditions occurred because Central Office guidance was not sufficiently clear as to what are allowable HISA services. Also, Department of Veterans Affairs (VA) Medical Center (VAMC) staff did not follow certain established program procedures. As a result, some veterans received home improvements that should not have been approved, while other veterans had their lifetime HISA benefits used unnecessarily—thereby denying them use of these funds for appropriate home improvements at a later time.

#### **HISA Projects Should Improve Accessibility or Ensure Continuation of Treatment**

M-1, Part I, Chapter 16, Paragraph 16.69b states that the medical eligibility (i.e., medical necessity) determination will include determining whether the requested home improvement or structural alteration is necessary or appropriate for the effective and economical treatment of a disability. It further states that the medical eligibility determination will ensure the continuation of treatment of the disability or provide access to the home or to essential lavatory and sanitary facilities.

In 175 cases reviewed, we determined that the home improvement was not medically necessary in 26 (15 percent) cases because the project scope, or a portion of it, did not have any relationship to treatment or accessibility issues. We confirmed our conclusions on these projects with physicians who either agreed with us (11 cases) or did not object to our conclusions once they were presented to them. In the latter case, the physicians liberally interpreted the regulations and believed that the approval they gave was within the intent of the regulations. In some cases, staff did not consider alternatives. For example, one veteran, who was 100 percent service-connected for psychosis, was granted HISA benefits to remodel a bathroom. We found that not all alternatives were considered before the complete remodeling of the bathroom was approved. The veteran complained of dizziness caused by his medication which caused him to fall. We determined that handrails for the shower would have cost VA an estimated \$7.50. Because of potential liability, the veteran would have had to pay for installation. Instead of considering the

handrails, the HISA committee approved replacing the shower stall, tile, and sink at a cost of \$4,036. Since the veteran was ambulatory, we asked the HISA physician if handrails would have been appropriate. The HISA physician agreed that handrails would have been a suitable alternative. As a result, more renovation was done than necessary which had an adverse impact on the veteran's future eligibility for HISA benefits.

In other cases, staff approved projects without considering medical necessity. They believed that if a veteran was legally eligible and the project cost did not exceed the veteran's HISA limitation, they did not need to review the scope of the project. However, M-1, Part I, Chapter 16, Paragraph 16.71f requires staff to differentiate between reasonably necessary improvements for medical treatment (allowable HISA services) and those which are useful, lend to the comfort of the individual, or make life outside the facility more acceptable (not allowable HISA services). As a result, portions of some projects were not medically necessary and should not have been paid for with HISA funds. For example:

Staff approved three projects for wheelchair ramps with large decks. According to VAMC staff, a six-by-six foot landing is generally sufficient to provide turnaround space for a wheelchair. Therefore, the larger decks built in these projects were excessive. Staff at one of the facilities where the larger decks were built agreed that these decks should not have been approved. Staff at another facility stated that they understood our interpretation, but thought that the guidelines did not clearly define what was allowable.

Staff approved a project to install a handrail, replace outside steps and a window, and build a deck. However, we found that, as the treating physician had requested, the veteran only needed a handrail. (*See Appendix III, Page 19 for discussion of other projects that did not improve accessibility.*) The HISA Coordinator stated that there was not sufficient information in the file to show why the steps, window, and deck were necessary, and she agreed that only necessary items should be approved.

These projects were approved because VA criteria did not sufficiently define allowable HISA services. M-1, Part I, Chapter 16, Paragraph 16.68c identified the following four examples as allowable HISA services:

- Construct permanent wheelchair ramps.
- Widen doorways for wheelchair access.
- Lower kitchen or bathroom counters and sinks to permit needed access for wheelchair patients.
- Improve otherwise inaccessible entrance paths and driveways.



However, specific examples were not provided, and, as noted above, some VAMC staff used a liberal interpretation in determining what services provided accessibility.

As a result, projects totaling \$36,780 were approved that were not medically necessary. In addition, some of the costs for the projects whose scopes were partially unnecessary were not proper. These projects with questionable scopes totaled \$30,287; however, we could not determine what portion of the costs related to unnecessary items because the invoices did not contain sufficiently detailed cost information.

Some VA requirements were not followed. We believe the control weaknesses listed below contributed to an environment that allowed inappropriate approval of some projects.

- Local policies were not published or did not adequately instruct staff to differentiate between necessary and useful improvements.
- Some medical necessity determinations were made by someone other than the committee members or a physician.
- The HISA committee chairperson was not a physician at some facilities.
- Some HISA benefits were paid even though prior approval was not obtained.
- Legal eligibility and medical necessity determinations were not documented in some cases.

*(See Appendix III, Page 20 for discussion of other causes for approval of projects that were not medically necessary.)*

### **Some HISA Projects Should Have Been Paid From PSAS Funds**

M-1, Part I, Chapter 16, Paragraph 16.68f states that the HISA cost limitation pertains only to improvements and structural alterations and medical equipment, if the equipment is relatively immobile and its installation is considered a capital improvement and/or permanent addition. In determining whether an item is a permanent addition, consideration should be given to whether the item can be removed without major alteration or damage to the house. Paragraph 16.68g states that routine, minor work to install removable equipment (e.g., installing an electrical outlet or switch, a simple floor, wall, ceiling or window attachment related to installing removable equipment) is chargeable as a PSAS item and not a HISA item.

In 175 cases reviewed, 23 (13 percent) included items that should have been paid from PSAS funds. For example, 18 of these cases totaling \$17,275 involved installing a wheel-o-vator. The wheel-o-vator, which is a removable item of equipment, was paid from PSAS funds. However, the cost to install was paid from HISA funds. The installation included constructing a concrete pad, installing wiring, and in some cases leveling the

porch or entrance to the home. These installation costs averaged \$960 and ranged from \$600 to \$1,750. The other five cases totaling \$2,251 were for

- lift and swing installation on existing track (\$300),
- stair lift installation (\$900),
- grab bars and handrails in bathroom (\$365),
- window air conditioner (\$376), and
- removable wheelchair ramps (\$310).

Because the VA guidelines pertaining to routine/minor installation work were not clear, the medical center staff were able to liberally interpret the regulations and use HISA funds for these installations. Also, in three cases, VAMC staff mistakenly used HISA funds for removable equipment. As a result, 23 veterans may have unnecessarily used up their HISA lifetime limitations because the wrong funds were used to fund their projects. Since this is a lifetime limitation, resources that would have been available to them for future HISA services were unnecessarily limited.

### **HISA Projects Should Not Duplicate Services Provided By Prior SAH Grants**

M-1, Part I, Chapter 16, Paragraph 16.68i allows HISA benefits to veterans who have received SAH benefits, except when the improvements were already furnished as part of the SAH benefit. Also, Veterans Benefits Administration (VBA) Manual M26-12, Section 3.03 outlines minimum property requirements for a SAH grant. Paragraph 3.03 a(1) states that, to qualify for the grant, the housing unit must include those features necessary to accommodate the veteran's disabilities.

In 175 cases reviewed, 4 provided services that were also provided by an SAH grant as discussed below.

A veteran received an SAH grant of \$38,000 in 1993 for a new house. In 1994, he received HISA benefits totaling \$1,600 for a sidewalk around the back of the house to provide egress. However, M26-12 states that this item is a minimum requirement to receive SAH funding. Specifically, Paragraph 3.03a(3)(a) states that at least two ramps suitable for ingress and egress must be included. Therefore, in our view, the veteran had already received benefits for this egress and the HISA benefit should not have been allowed.

A veteran received an SAH grant of \$38,000 in January 1995 for a new house. In the same month, he received HISA benefits totaling \$4,100 for central air conditioning. However, M26-12, Paragraph 3.03a(3)(m) states that, when climate and the nature of the veteran's disability dictate, air conditioning will be made a

condition of the SAH grant. Therefore, in our view, the veteran improperly received two benefits for the same central air conditioning system.

A veteran received an SAH grant of \$38,000 in November 1995 for a new house. In the same month, he received HISA benefits totaling \$940 for a wheelchair ramp in his garage for access to the house. However, M26-12, Paragraph 3.03 a(1) requires that the housing unit include those features necessary to accommodate the veteran's disabilities. In our view, wheelchair access from the garage to the house was a necessary feature for this veteran's disabilities. Therefore, the veteran improperly received two benefits for the same home improvement.

A veteran received an SAH grant of \$35,500 in March 1988 for a new house. In March 1993, he received HISA benefits totaling \$4,100 for a roll-in shower. However, M26-12, Paragraph 3.03a(f)8 states that at least one bathroom should include a stall shower with no curb between the stall and bathroom. Therefore, the veteran improperly received two benefits for the same home improvement.

These duplications occurred because VAMC staff did not routinely or sufficiently determine whether the veteran had a prior SAH grant and, if so, what that grant was for. There were no VA guidelines requiring VAMC staff to query the Regional Office for prior SAH grants. Also, in two cases, VAMC staff advised us that they used a liberal interpretation in order to maximize the amount the veteran could receive. As a result, \$10,740 was paid inappropriately.

### **Recommendation 1**

We recommend that the Under Secretary for Health:

- a. Define the services that are appropriate for providing accessibility or ensuring the continuation of treatment. This may include providing examples of allowable projects in VHA policy guidance.
- b. Notify all facilities of the medical necessity requirements.
- c. Define the services that should be funded through the HISA program versus the PSAS program.
- d. Establish guidelines requiring that prior SAH benefits be reviewed and HISA benefits be awarded accordingly.

*The associated monetary benefits for Recommendation 1 are shown in Appendix IV on page 23.*

### **Under Secretary for Health Comments**

**Recommendation 1a.** Concur. The Prosthetic and Sensory Aids Service Strategic Healthcare Group (113) is in the process of developing a new and comprehensive VHA directive on the HISA program which will fully define and clarify specific services and projects that appropriately fall within the HISA program scope of authority. Examples of both allowable and nonallowable situations will be provided. Prior to undergoing the formal VHA concurrence process, the draft directive will be reviewed and approved by the Council of Prosthetic and Sensory Aids Chiefs, who will provide needed field input. Implementation: December 31, 1996.

**Recommendation 1b.** Concur. The proposed directive will include specific guidance about the need to differentiate between those services/projects that are necessary to improve access to and within the home or to ensure the continuation of necessary treatment at home and those services that might merely provide more comfort. Implementation: December 31, 1996.

**Recommendation 1c.** Concur. Such guidance will also be included in the directive so that liberal interpretation of regulations will be minimized. What constitutes routine or minor installation work that should be funded through PSAS will be clarified in the publication. Implementation: December 31, 1996.

**Recommendation 1d.** Concur. This guidance will also be clarified in the directive. Common sense guidelines will be included to further explain what constitutes duplication of service. Implementation: December 31, 1996.

### **Office of Inspector General Comments**

The Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. We consider all audit issues resolved and will follow up on the implementation plans.

## **2. Improved Financial Management Is Needed To Ensure Program Funds Are Efficiently Used and Properly Monitored**

Staff at 10 VAMCs were not adequately identifying veterans for the HISA program because they did not have sufficient funds available for additional HISA grants. Also, staff at four of the six VAMCs we visited had not made required retroactive payments to veterans when the program limitations increased in 1992. In addition, program funds were not adequately controlled at any of the six VAMCs visited because staff did not follow Veterans Health Administration (VHA) procedures in M-1, Part I, Chapter 16. As a result, some veterans, including some having highly visible disabilities, were not aware that they were entitled to HISA benefits or entitled to the additional benefits. Also, because funds were not adequately controlled at the six VAMCs: some veterans received payments exceeding their lifetime limits; program costs could not be accurately monitored by program officials; and, unused program funds were not timely deobligated for other use.

### **VAMCs Should Actively Identify Veterans for the HISA Program**

One audit objective focused on evaluating patient participation in the program and determining reasons for high and low use. We visited six VAMCs and found high patient participation at five VAMCs. These five VAMCs publicized the program to clinical staff and service organizations who, in turn, informed veterans of their rights to apply for HISA benefits. Staff at the other VAMC did not publicize the HISA program because of resource limitations. Resource managers said they did not have sufficient funds available for additional HISA grants that might be generated by publicizing the program. However, they emphasized that all eligible veterans who applied for HISA benefits received them. At this VAMC, we contacted 10 veterans who recently received electric wheelchairs and found that 7 were not aware of the HISA program. Three of these veterans, one service-connected (SC) and two nonservice-connected (NSC), used their personal funds to pay for wheelchair ramps to provide access to their homes.

We sent questionnaires to all VAMCs to determine how staff identified veterans needing HISA benefits. Nine VAMCs had not established a systematic method for identifying veterans eligible for the program. We concluded from our evaluation of patient participation in the program that these 10 VAMCs should more actively identify veterans for the HISA program.

## **Retroactive Payments Were Required When HISA Benefits Increased**

In October 1992, Congress passed Public Law 102-405, which increased the monetary awards for HISA benefits. The increased benefits were made retroactive to January 1, 1990. The benefits increased from \$2,500 to \$4,100 for SC disabilities and from \$600 to \$1,200 for NSC disabilities. VHA officials directed VAMC staff to retroactively compensate veterans, who received benefits after January 1, 1990, for allowable expenditures that exceeded the old limits.

At the 6 VAMCs visited, we reviewed 175 HISA grants to determine whether the required retroactive payments were made. At two VAMCs, none of the veterans we reviewed made payments that exceeded the limitations and, therefore, did not qualify for retroactive reimbursements. At the other four VAMCs, eight veterans were not compensated retroactively when the benefits increased. In addition to our sample of 175 grants, at one VAMC we reviewed all payments after January 1, 1990, and found 12 additional veterans who were not reimbursed retroactively when the benefits increased. VAMC staff said they were aware of the requirement, but they were waiting for the veterans to request the additional benefits. Since these veterans had already reached the limits set by the earlier legislation, they had no incentive to request additional benefits or reimbursement. Realistically, they would not know they were entitled to the additional benefits or reimbursement. The amounts the 20 veterans should have been reimbursed totaled \$14,400. Based on the results of our review at the six VAMCs we visited, there may be other VAMCs that have not made the retroactive payments.

## **Program Funds Should Be Better Controlled**

Our review of the adequacy of financial oversight of the HISA program determined that control over program funds needed improvement at all six VAMCs visited.

**Prior Benefits Paid Should Be Documented** - As part of the HISA program, VAMC staff are required to establish records to show HISA benefits paid to veterans. M-1, Part I, Paragraph 16.73 requires a HISA control card or suitable computer equivalent to identify all HISA payments. Further, it requires copies of all payment vouchers to be forwarded to the regional office for filing in the veterans' claim folders and copies to be filed in the administrative section of the veterans' medical files. According to M-1, Part I, Paragraph 16.71, HISA staff should use these records to determine veterans' unused lifetime benefits when determining eligibility. This is done to ensure payments to veterans do not exceed their lifetime HISA limits. Our review at the six VAMCs disclosed that these records were not accurate and did not identify benefits paid.

- One VAMC did not maintain/use HISA cards; and, at the other five VAMCs, the HISA cards were not accurate. For example, payments were made to some

veterans who did not have HISA control cards. Other veterans had cards, but the payments were not recorded or were not correct. In other instances, the approval dates and obligation numbers on the HISA cards were inaccurate.

- Five VAMCs did not forward copies of payment vouchers to the regional office for filing in the veterans' claim folders. One VAMC forwarded copies of the payment voucher to the regional office, but the regional office returned the copies. A veteran's claim folder should identify all HISA benefits the veteran received because SAH program staff review these files and prepare a statement for the SAH file as to whether or not the veteran received HISA benefits. The purpose is to avoid duplicate benefit payments between the HISA and SAH programs.
- Four VAMCs did not file copies of the payment vouchers in the administrative section of the veterans' medical files. One purpose is to avoid exceeding veterans' lifetime limitations. In the event a veteran transfers to another VAMC for benefits, the medical file would also be transferred and should show the HISA benefits that have previously been paid.

The payment records were not accurate because staff were not aware of the requirements or did not follow them. As a result of these inaccuracies, we determined that two veterans received HISA payments exceeding their lifetime limitations by \$1,872. Also, as discussed previously, we identified duplicate payments between the HISA and SAH programs. In our view, VAMC staff should maintain the required records electronically rather than manually. They should consider recording HISA benefit payments in existing automated records such as VBA's TARGET system, the proposed new PSAS software package, and Veterans Master Record (pending development).

**Monitoring Program Costs** - PSAS officials need accurate cost data to monitor HISA program costs. Program cost reporting needed improvements.

- The six VAMCs used different fund control points (codes unique to each VAMC in VA's accounting system) to record HISA budget amounts. M-1, Part I, Chapter 16 does not require accounting for program costs by SC and NSC veterans. As a result, VHA officials could not determine nationwide HISA program costs for SC and NSC veterans. VA implemented a new accounting system, Financial Management System (FMS) in October 1995 and replaced the fund control points with Accounting Classification Codes (ACCs). For the HISA program, FMS established ACCs for SC costs and for NSC costs. However, for Fiscal Year (FY) 1996, three VAMCs did not use the established ACCs.

- HISA payments of \$13,000 were charged to non-HISA accounts, and \$6,000 of non-HISA payments were charged to the HISA account. VA's accounting procedures require all HISA payments to be recorded to an account titled, "Cost Center 8601."

**Follow-up Should Be Timely** - VAMC staff did not timely follow up on approved projects that were not completed and did not deobligate the unused funds associated with these projects.

- At one VAMC, we found 216 pending HISA grants totaling \$413,624. These included 59 projects that were approved prior to FY 1995. HISA staff were still waiting for the veterans to complete the alterations and submit a request for reimbursement.
- At each VAMC, accounting staff provided HISA staff a budget of available funds. As each veteran's HISA benefit was approved, the HISA staff would use (or obligate) some of the budgeted funds. At two VAMCs, HISA staff did not obligate all their budgeted funds, yet they did not return the unused funds (deobligate) to the accounting staff before year-end. At another VAMC, a veteran died in September 1995, after his HISA project was approved but before it was started. At the time of our review in April 1996, the funds had not been deobligated. As a result, at the three VAMCs, unused HISA funds totaling \$95,690 could not be used for other medical care needs.

**Controls over Payments** - Improvements were needed at all six VAMCs visited.

- VA policy contained in M-1, Part I, Paragraph 16.73 states that the certification of vouchers for payments or reimbursements will only be made after receiving written confirmation from the veteran or veteran's representative that the authorized services were furnished. We reviewed 175 HISA projects and found confirmations that work was completed for 101 of the projects (58 percent). Not all of these confirmations were in writing or from the veterans. Some confirmations, for example, consisted of veterans certifying by phone or submitting photos, building inspectors certifying completion of work, and Engineering Service staff conducting inspections. We considered these confirmations to meet the intent of VA policy. However, we did not find any confirmations that work had been completed for 74 projects (42 percent). This occurred because staff did not follow procedures. As a result, payments were made without assurance that the projects were completed.

Some payments were made to the veterans rather than the contractors. According to MP-4, Part III, Chapter 4, the Internal Revenue Service (IRS) requires VA to issue Forms



1099 (1099s) for payments involving contractual services. IRS uses the 1099s to verify reported income. However, when payments are made to the veterans, rather than the contractors, a 1099 is not issued. Making payments to the contractors would ensure a 1099 is generated, enabling the IRS to verify reported income.

## **Recommendation 2**

We recommend that the Under Secretary for Health:

- a. Ensure all facilities publicize the HISA program, actively identify eligible veterans, and inform them of their rights to apply for HISA benefits.
- b. Notify all facilities of the requirement to make the retroactive payments to veterans.
- c. Improve program financial controls by
  - (1) Electronically recording HISA payments—through coordination with VBA to code HISA payments into TARGET and by using the Prosthetic Service package at each VAMC—pending development of the Veteran Master Record.
  - (2) Requiring facilities to use the ACCs established by FMS for SC and NSC costs and to monitor HISA costs to ensure they are charged to the correct cost center.
  - (3) Establishing a time limit, such as 90 days, for veterans to complete approved projects and then following up after this time to determine whether the project is still necessary.
  - (4) Notifying all facilities of the need to timely deobligate unused funds.
  - (5) Notifying all facilities of the need to obtain confirmations when projects are completed.
  - (6) Requiring facilities to make payments to the contractors rather than the veterans.

*The associated monetary benefits for Recommendation 2 are shown in Appendix IV on page 23.*

## **Under Secretary for Health Comments**

**Recommendation 2a.** Concur. This requirement will be highlighted in the directive. In addition, upon publication of the directive, the Chief Network Officer will include a discussion of the HISA program, including expectations from all field facilities, at one of the regularly scheduled weekly conference calls that include participation by top managers from all facilities. A copy of this OIG report will also be distributed to all facilities. Implementation: January 1997.

**Recommendation 2b.** Concur. This requirement will be communicated to all field facilities via the directive and regularly scheduled conference calls. VAMCs will be instructed to review HISA costs from January 1, 1990, through November 1992 to identify all veterans eligible for retroactive reimbursement under the provision of P.L. 102-405. Implementation: January 1997.

**Recommendation 2c(1).** Concur. The Prosthetic and Sensory Aids Service will initiate coordinated actions with VBA staff to incorporate HISA payments into the TARGET system. At a minimum, the Prosthetic DHCP package will also be modified to include HISA benefits as part of the veteran's electronic 2319. Implementation: December 31, 1996.

**Recommendation 2c(2).** Concur. Although we are unaware of existing ACCs in FMS for SC and NSC HISA beneficiary costs, we will request that such codes be established by the Deputy Assistant Secretary for Financial Management (047). All VAMCs will then be required to use the designated classification codes. The Prosthetic and Sensory Aids Service will also continue to carefully monitor the HISA cost center (601) to further ensure appropriate application of HISA benefits. Implementation: January 1997.

**Recommendation 2c(3).** Concur. A time limit will be established. Processing specifications will be addressed in the new directive and discussed during selected Network/program office conference calls. Implementation: January 1997.

**Recommendation 2c(4).** Concur. This information will also be communicated to all field facilities through the mechanisms described previously. Implementation: December 31, 1996.

**Recommendation 2c(5).** Concur. Written confirmation will be required prior to payment in all instances. Again, guidance to this effect will be incorporated into the directive and communicated throughout the system. Implementation: December 31, 1996.

**Recommendation 2c(6).** Concur with exceptions. The exceptions would involve veterans who are provided retroactive payments and those rare instances that might warrant direct reimbursement to the veteran. These exceptions will be stipulated in the directive. Implementation: December 31, 1996.

**Office of Inspector General Comments**

The Under Secretary for Health concurred with the recommendations and provided acceptable implementation plans. We consider all audit issues resolved and will follow up on the implementation plans.

### **3. Concern Over Funding the HISA Program**

Funding of the HISA program was an area of concern to PSAS officials. In their view, annual program costs may soon double to \$8 million. This was based on the premise that PSAS staff, who recently were given responsibility for managing the HISA program, will better publicize the program and provide HISA benefits to more veterans. The HISA program competes with other medical programs for the medical care appropriation funds allotted to each VAMC. As a result, some VAMCs with limited funds did not provide much funding for the HISA program. Other VAMCs, particularly those with larger budgets, spent significant amounts for the program.

PSAS officials preferred centralized control of funding, instead of the current local funding, because they believed they could ensure that adequate funds were spent on the HISA program. In February 1995, PSAS officials requested that HISA funding be centralized. The Budget Planning Review Council disapproved the request, stating that funding for the program was effectively managed as part of the local facility's base. Our audit disclosed that some VAMCs did not have adequate funds to provide HISA benefits to all veterans who needed home alterations.

- At one VAMC we visited, the resource manager was concerned that his VAMC would not have adequate HISA funds available in FY 1996 if more veterans applied for HISA benefits.
- At another VAMC, a SC veteran's grant application was reviewed and approved. However, VAMC staff had to deny the veteran the benefits because the local resource committee said that funds were not available for the HISA program. The resource committee also said funds were not available for other pending HISA grant requests.

In our view, this funding question addresses a larger policy issue—priority of medical care funds. The HISA funding is part of the discretionary budget of the medical center. The legislation for the HISA program, 38 United States Code 1717 (a)(2) states, "Improvements and structural alterations may be furnished." In implementing the legislation for the HISA program, we believe that VHA officials need to determine to what additional degree, if any, this program should receive priority funding considerations.

## OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

The primary objectives of the audit were to determine whether program funds were properly used, to evaluate whether patient participation in the program was adequate or excessive, and to assess the adequacy of financial and management oversight of the program. The audit was initiated at the request of the Under Secretary for Health.

### Scope and Methodology

The scope of the audit included HISA benefits paid for the period October 1, 1990, to March 31, 1996. According to Centralized Accounting for Local Management (CALM), HISA payments totaled over \$19 million during this five and one-half year period.

We initiated our audit with a review of Public Laws and VHA Directives and procedural manuals to identify requirements and potential audit issues. Six VAMCs were selected for review based on HISA activity as indicated by costs reported in CALM. We selected high, low, and medium users of the program. Also, we obtained and used input from the Director, PSAS regarding site selection. (*Appendix III, page 22, provides a brief description of each VAMC.*)

The initial phase of our audit included four major reviews and tests at two VAMCs (VAMCs Denver, Colorado and Houston, Texas). Based on the audit results at these two sites, we continued with the same major reviews and tests as described below at four additional sites.

- Reviewed a random sample of 175 HISA files (30 at each site except VAMC Iowa City, which had only 25 cases) to determine whether legal and medical eligibility determinations and payments were proper.
- Inspected 34 projects to determine whether they were completed satisfactorily.
- Interviewed appropriate facility staff, veterans, and veterans service organizations to assess the level of patient participation.
- Reconciled CALM costs to source documents such as purchase orders.

We also sent questionnaires to all facilities to obtain cost and program information. We analyzed this information to help verify costs, identify what types of veterans were using the program, and identify procedures used to publicize the program, verify eligibility, and make payments.

We used computerized data for two purposes. First, we used cost data from the CALM and the FMS to identify potential audit sites. The data was not critical to the accomplishment of the audit objectives. The reliability of the data was assessed by

comparing CALM/FMS data to VAMC cost reports and individual purchase orders. As noted in Issue 2 (page 7), some of the CALM/FMS data was found to be inaccurate. However, we concluded the data were sufficiently reliable to be used in meeting the assignment's objectives.

Second, we used Integrated Funds Control Point Activity Accounting and Procurement (IFCAP) data to identify the universe of HISA payments at individual VAMCs. To assess the reliability of this data, we compared IFCAP data to HISA records and found it was accurate.

The audit was made in accordance with generally accepted government auditing standards and included such tests of the procedures and records as were deemed appropriate under the circumstances. Internal controls pertaining to the areas reviewed were analyzed and evaluated. The audit included program results, economy and efficiency, and financial and compliance elements.

## **BACKGROUND**

In October 1976, Public Law 94-581, The Veterans Omnibus Health Care Act of 1976, amended Sections 612 (a) and (f) of Title 38 U.S.C. to extend the home health services authority to include home improvements and structural alterations which were necessary to ensure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities. Veterans are eligible for HISA benefits when medically determined to be necessary or appropriate for the effective and economical treatment of a

- SC disability,
- NSC disability of a veteran rated at 50 percent or more SC,
- NSC disability of a veteran who is receiving authorized posthospital care, or a
- NSC disability of veteran of World War I, or the Mexican Border Period, or of a veteran in receipt of Aid & Attendance or housebound benefits.

Each veteran has a lifetime benefit limitation. In 1976, the HISA benefit was limited to \$2,500 for treatment of an SC disability or any disability of a veteran with an SC rating of 50 percent or more. Treatment of an NSC condition of any other veteran was limited to \$600. Public Law 102-405, dated October 9, 1992, increased these limitations to \$4,100 and \$1,200, respectively, and was made retroactive to January 1, 1990.

Improvements and structural alterations chargeable against the veterans' cost limitations include, but are not restricted to

- constructing permanent wheelchair ramps,
- widening doorways for wheelchair access,
- lowering kitchen or bathroom counters and sinks to permit needed access for wheelchair patients, and
- improving otherwise inaccessible entrance paths and driveways.

HISA benefits are paid from the Medical Care Appropriation. During the five and one-half year period ended March 31, 1996, we estimate that approximately 11,000 veterans received HISA benefits totaling \$19.4 million as shown on the following chart.

**PROGRAM STATISTICS**

<b><u>Fiscal Year</u></b>	<b><u>Number of Veterans</u></b>	<b><u>Cost (millions)</u></b>
1991	1,349	\$1.8
1992	1,501	\$2.0
1993	1,938	\$3.6
1994	2,298	\$4.6
1995	2,728	\$5.3
1996 thru March	<u>1,185</u>	<u>\$2.1</u>
<b>Totals</b>	<b><u>10,999</u></b>	<b><u>\$19.4</u></b>



## **DETAILS OF AUDIT**

### **Other Projects That Did Not Improve Accessibility**

VAMC staff approved two projects for new bathrooms so the veterans could have bathrooms closer to their bedrooms. We found no evidence that the veterans' disabilities caused access difficulties to the existing bathrooms. The new bathrooms, while convenient, were not necessary. We also found that there was no consideration for alternatives such as moving the veterans to bedrooms closer to the existing bathrooms. The HISA physician agreed that this was a feasible alternative and the projects were for the veterans' convenience.

VA staff approved 13 other projects to either remodel or build new bathrooms. Again, we found no evidence of accessibility problems, and VA staff could not explain why the projects were necessary to improve accessibility. The HISA physician agreed that these projects should either not have been approved or should have been reduced in scope. For example:

One veteran received HISA payments totaling \$3,728 to repair the roof and remodel the bathroom, including new cabinets. The HISA committee concluded that the veteran was medically eligible for HISA benefits not to exceed \$4,100 because of schizophrenia and a right leg nerve injury. The HISA physician agreed that replacing the bathtub with a shower stall was justified because of the leg injury, but the rest of the project scope was not justified.

VA staff approved three projects related to security issues. Two projects installed iron railings and gates, and the third project installed an intercom system. In each case, the HISA committee concluded that the veterans would be more secure in their homes with these items. In one case, an iron railing was installed around the balcony so the veteran, who had Alzheimer's and Parkinson's diseases, would not wander away. We found that this railing was only four feet high. The HISA physician agreed that this made the balcony unsafe and the project should not have been approved. As noted earlier, the HISA committee should differentiate between what is necessary for accessibility or treatment and what is useful or convenient. In our view, while these items were useful, they were not necessary.

**Other Causes For Approval of Projects That Were Not Medically Necessary**

Local policies were not published or did not adequately instruct staff

M-1, Part I, Chapter 16, paragraph 16.71f requires that HISA Committee instructions be developed and published by each health care facility. The instructions will contain explanatory information that HISA may not be authorized unless it is specifically related to the actual treatment process or provides access to the home or to essential lavatory or sanitary facilities. The instructions will tell the committee to differentiate between reasonably necessary improvements for medical treatment and those which are useful and lend to the comfort of the individual or make life outside the facility more acceptable, but are not considered necessary for medical treatment or to gain access to the home.

Local policy at five of the six sites visited did not instruct the committee to differentiate between necessary and useful improvements. Also, in response to our nationwide questionnaire, 21 facilities did not provide any local written policy.

Some medical necessity determinations were made by someone other than the committee members or a physician

M-1, Part I, Chapter 16, Paragraph 16.71d requires the HISA Committee to review all applications from legally eligible veterans to determine and document medical necessity. Paragraph 16.69a(3) requires a physician to determine and document the medical necessity. At three of the six sites we visited, a HISA Committee was not established and therefore was not involved in the determination. In 53 of the 175 cases reviewed, a nonphysician determined medical necessity. Nonphysician staff making these determinations included the Chief, Medical Administrative Service; the Chief, PSAS; and a nurse acting for the physician.

Responses to our nationwide questionnaire indicated that four facilities had not established a committee and four other committees did not include a physician. Also, at 66 facilities, neither the committee nor the treating physician were involved in the determination.

The HISA committee chairperson was not always a physician

M-1, Part I, Chapter 16, paragraph 16.71e requires that the chairperson of the HISA committee be a physician. One of the three sites that we visited, that had established a committee, had a nonphysician as the chairperson. Additionally, in response to our nationwide questionnaire, 28 facilities indicated that nonphysicians were the chairpersons for their committees.

### Some HISA benefits were paid even though prior approval was not obtained

M-1, Part I, Chapter 16, Paragraph 16.73b states that reimbursement for HISA can be made only when prior VA authorization was obtained for the HISA benefit.

In 21 cases at one facility, VAMC staff did not approve the HISA application until after the project was completed. In 3 cases, staff were unaware of the projects or the veterans' needs until after the projects were completed. For the other 18 cases, staff were aware of the request for HISA services; however, they had not completed their legal eligibility and/or medical necessity determinations prior to completion of the project. We questioned the medical necessity of portions of 3 of the 21 projects. The Chief, PSAS agreed that payment should only be allowed for projects that have prior approval.

### Legal eligibility and medical necessity determinations were not always documented

M-1, Part I, Chapter 16, Paragraph 16.70a states that, upon receipt of an application for home improvements or structural alterations, the health care facility closest to the veteran's home or the health care facility furnishing posthospital care is responsible for processing and completing action on VA Form 10-0103, for veterans eligible for home improvements or structural alterations. Paragraph 16.69a(2) states that legal eligibility will be determined and documented in Section II of VA Form 10-0103.

Of the 159 Forms 10-0103 reviewed, legal eligibility was not documented in 66 cases and medical necessity was not documented in 71 cases. For 16 cases, we could not determine whether legal eligibility or medical necessity was documented because the Forms 10-0103 were missing.

In some cases, this occurred because staff documented these decisions on internal memos or in committee meeting minutes, and the approving official signed a blank Form 10-0103. In other cases, applications were locally created and did not include the legal eligibility questions as required by M-1, Part I, Chapter 16. In our view, accountability would be strengthened and approving actions would be clearer if decisions were documented on the same form that the approving official signs. Also, Form 10-0103 was developed so that these decisions could be easily documented.

### **Description of Sites Audited**

#### **Medical Center**

#### **Description**

VAMC Denver

An affiliated, 276-bed tertiary care hospital with a 60-bed Nursing Home Care Unit (NHCU), an outpatient clinic in Colorado Springs, and a satellite clinic in Pueblo, Colorado. (VISN 19)

VAMC Houston

An affiliated, 877-bed tertiary care hospital with a 120-bed NHCU. (VISN 16)

VAMC Ann Arbor

An affiliated, 178-bed tertiary care hospital with a 60-bed NHCU. (VISN 11)

VAMC Iowa City

An affiliated, 269-bed tertiary care hospital with a satellite outpatient clinic in Bettendorf, Iowa. (VISN 14)

Edward Hines, Jr. VA Hospital

An affiliated, 747-bed tertiary care hospital with a 240-bed NHCU and 30 spinal cord injury beds. (VISN 12)

VAMC San Juan

An affiliated, 682-bed tertiary care hospital with a 120-bed NHCU and 20 spinal cord injury beds. (VISN 8)

**MONETARY BENEFITS**  
**IN ACCORDANCE WITH IG ACT AMENDMENTS**

**Report Title:** Audit of Department of Veterans Affairs Home Improvement and Structural Alterations Program

**Project Number:** 6R5-181

<b><u>Recommendation Number</u></b>	<b><u>Category/Explanation of Dollar Impact</u></b>	<b><u>Better Use of Funds</u></b>	<b><u>Questioned Costs</u></b>
<b>1a &amp; 1b</b>	Improved Use of Resources. Estimate of amount paid by VA for HISA services that did not improve accessibility or ensure continuation of treatment.	\$ 36,780	\$ -0-
<b>1c</b>	Improved Use of Resources. Estimate of amount paid by VA for HISA services that should or could have been paid from PSAS funds.	19,526	-0-
<b>1d</b>	Improved Use of Resources. Estimate of amount paid by VA for HISA services that duplicated services provided by SAH grants.	10,740	-0-
<b>2b</b>	Improved Use of Resources. Estimate of amount VA did not reimburse veterans when HISA benefits were increased.	14,400	-0-
<b>2c(1)</b>	Improved Use of Resources. Amount that total payments exceeded the lifetime limitation.	1,872	-0-

**APPENDIX IV**

<b>2c(3) &amp; 2c(4)</b>	Improved Use of Resources.	95,690	-0-
	Estimate of amount not deobligated at year-end and lost for other medical care needs.		
		<hr/>	<hr/>
		<u>\$179,008</u>	<u>\$ -0-</u>

## MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Department of  
Veterans Affairs

## Memorandum

Date: October 29, 1996

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report: ***Financial and Management Oversight of the Home Improvement and Structural Alterations Program (HISA)***

To: Assistant Inspector General for Auditing (52)

1. This report has been reviewed within VHA and we are in agreement with your findings, conclusions and recommendations. There is also no dispute with the estimate of monetary savings.
2. Your findings confirm that improved administration of the HISA program is needed to assure that eligible disabled veterans are given every possible opportunity to secure entitled benefits. As reported, administrative responsibility for the program has recently been re-assigned. The Prosthetic and Sensory Aids Service Strategic Healthcare Group (113) has initiated plans to provide appropriate oversight and accountability control that had been limited in the past. As detailed in the accompanying action plan, steps are already being taken to expand and update the official VHA program directive and to fully communicate all aspects of HISA requirements to our field facilities.
3. Funding options for HISA will continue to receive special attention since costs are expected to escalate and the program must compete for limited medical care appropriation funds. With renewed program emphasis and oversight accountability from a systemwide perspective, we anticipate that many of our medical facilities will also re-focus their funding priorities for HISA. Centralized funding control is therefore not being considered at this time pending an assessment of program activity within the coming months.
4. Thank you for the opportunity to respond to this report. If additional information is required, please contact Paul C. Gibert, Jr., Director, Management Review Service (105E), Office of Policy, Planning and Performance (105), at 273.8355.

[Signed by Thomas L. Garthwaite, M.D. for:]  
Kenneth W. Kizer, M.D., M.P.H.

Attachment

## MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: OIG Draft Report: ***Financial and Management Oversight of the Home Improvement and Structural Alterations Program (HISA)***

Report Number: Project No. 6R5-181

Date of Report: none

Recommendations/ Completion Actions	Status	Date
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**Recommendation 1 We recommend that the Under Secretary for Health:**

**a. Define the services that are appropriate for providing accessibility or ensuring the continuation of treatment. This may include providing examples of allowable projects in VHA policy guidance.**

**Concur**

The Prosthetic and Sensory Aids Service Strategic Healthcare Group (113) is in the process of developing a new and comprehensive VHA directive on the HISA program which will fully define and clarify specific services and projects that appropriately fall within the HISA program scope of authority. Examples of both allowable and non-allowable situations will be provided. Prior to undergoing the formal VHA concurrence process, the draft directive will be reviewed and approved by the Council of Prosthetic and Sensory Aids Chiefs, who will provide needed field input.

In Process

December 31, 1996

**b. Notify all facilities of the medical necessity requirements.**

**Concur**

The proposed directive will include specific guidance about the need to differentiate between those services/projects that are necessary to improve access to and within the home or to ensure the continuation of necessary treatment at home and those services that might merely provide more comfort.

In Process

December 31, 1996



## MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Page 2 Action Plan: OIG Draft Report/HISA Program

**c. Define the services that should be funded through the HISA program versus the Prosthetic and Sensory Aids Service (PSAS) program.**

Concur

Such guidance will also be included in the directive so that liberal interpretation of regulations will be minimized. What constitutes routine or minor installation work that should be funded through PSAS will be clarified in the publication

In Process

December 31, 1996

**d. Establish guidelines requiring that prior Specially Adapted Housing (SAH) program benefits be reviewed and HISA benefits be awarded accordingly.**

Concur

This guidance will also be clarified in the directive. Common sense guidelines will be included to further explain what constitutes duplication of service.

In Process

December 31, 1996

**Recommendation 2 We recommend that the Under Secretary for Health:**

**a. Ensure all facilities publicize the HISA program, actively identify eligible veterans, and inform them of their rights to apply for HISA benefits.**

Concur

This requirement will be highlighted in the directive. In addition, upon publication of the directive, the Chief Network Officer will include a discussion of the HISA program, including expectations from all field facilities, at one of the regularly-scheduled weekly conference calls that include participation by top managers from all facilities. A copy of this OIG report will also be distributed to all facilities.

Planned

January 1997

## MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Page 3 Action Plan: OIG Draft Report/**HISA Program**

**b. Notify all facilities of the requirement to make the retroactive payments to veterans.**

Concur

This requirement will be communicated to all field facilities via the directive and regularly-scheduled conference calls. VAMCs will be instructed to review HISA costs from January 1, 1990 through November 1992 to identify all veterans eligible for retroactive reimbursement under the provision of P.L. 102-405.

Planned

January 1997

**c. Improve program financial controls by**

**1) Electronically recording HISA payments - through coordination with VBA to code HISA payments into TARGET and by using the Prosthetic Service package at each VAMC - pending development of the Veteran Master Record.**

Concur

The Prosthetic and Sensory Aids Service will initiate coordinated actions with VBA staff to incorporate HISA payments into the TARGET system. At a minimum, the Prosthetic DHCP package will also be modified to include HISA benefits as part of the veteran's electronic 2319.

Planned

December 31, 1996

**2) Requiring facilities to use the Accounting Classification Codes (ACCs) established by the Financial Management System (FMS) for SC and NSC costs and to monitor HISA costs to ensure they are charged to the correct cost center.**

Concur

Although we are unaware of existing ACCs in FMS for SC and NSC HISA beneficiary costs, we will request that such codes be established by the Deputy Assistant Secretary for Financial Management (047). All VAMCs will then be required to use the designated classification codes. The Prosthetic and Sensory Aids Service will also

## MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Page 4 Action Plan: OIG Draft Report/**HISA Program**

continue to carefully monitor the HISA cost center (601) to further ensure appropriate application of HISA benefits.

In Process

January 1997

**3) Establishing a time limit, such as 90 days, for veterans to complete approved projects and then following up after this time to determine whether the project is still necessary.**

Concur

A time limit will be established. Processing specifications will be addressed in the new directive and discussed during selected Network/program office conference calls.

Planned

January 1997

**4) Notifying all facilities of the need to timely deobligate unused funds.**

Concur

This information will also be communicated to all field facilities through the mechanisms described previously.

Planned

December 31, 1996

**5) Notifying all facilities of the need to obtain confirmations when projects are completed.**

Concur

Written confirmation will be required prior to payment in all instances. Again, guidance to this effect will be incorporated into the directive and communicated throughout the system.

Planned

December 31, 1996

**6) Requiring facilities to make payments to the contractors rather than the veterans.**

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH

Page 5 Action Plan: OIG Draft Report/**HISA Program**

Concur with Exception

The exceptions would involve veterans who are provided retroactive payments and those rare instances that might warrant direct reimbursement to the veteran. These exceptions will be stipulated in the directive.

Planned

December 31, 1996

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