Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program

Report No. 02-00124-48 **December 18, 2003**

VA Office of Inspector General
Washington, DC 20420

EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration's (VHA) Homemaker and Home Health Aide (H/HHA) Program. The evaluation was conducted to determine whether H/HHA programs at VA medical facilities were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost effective, and met customer expectations.

As part of the OIG's Combined Assessment Program (CAP) reviews, we inspected H/HHA programs at 17 VA medical facilities. We sampled 142 patients at 16 sites who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. Although the VHA Directive related to H/HHA Program operations expired in December 1997, continued compliance is expected until a new policy is issued.

Our reviews showed that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility.

We also found that 12 (8 percent) of 142 patients did not have any activities of daily living (ADL) dependencies documented in their initial assessments for H/HHA services, yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, 7 (10 percent) of the 70 respondents we interviewed said that they would not be in need of nursing home placements at this time even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions prescribed by VA policies and procedures.

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical facilities visited had waiting lists for placements in their programs. One facility had 23 patients on its waiting list, with one patient waiting 6 months for services. Another facility had eight patients on its H/HHA waiting list, one of whom had been on the list for 8 months.

In addition, we did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed. VHA policy requires that the physician, nurse, and social worker, at a minimum, complete an interdisciplinary assessment of a patient's need for H/HHA services.

We found many areas wherein program managers did not comply with VHA policy. All but 1 VA medical facility had designated coordinators of the programs; however, 8 (47

percent) of 17 facilities did not have local oversight committees monitoring program operations or the quality of patient care. Policy requires that VHA employees reassess their patients' continued needs for services every 3 months. We found that only 8 (47 percent) of 17 VA medical facilities were performing these reassessments in the time frame prescribed. Timely reassessments are necessary to evaluate patients' continued needs for services, and to reallocate resources to wait-listed patients whenever possible.

Community health agencies (CHAs) provided quarterly documentation of performance improvement activities to VA program managers in only 3 (18 percent) of 17 facilities visited. H/HHA Program managers cannot adequately monitor quality of care without reviewing CHAs' quality assurance measures and outcome data. Although VHA policy requires that only licensed providers be utilized, we found that six VA medical facilities visited allowed some unlicensed CHAs to provide services to VA patients. This occurred mostly in localities with limited home health care resources, and usually applied to homemaker services only.

VHA has not established guidelines for contracting for H/HHA services or provided contracting officers with benchmark rates for determining the reasonableness of charges as recommended in a 1997 OIG report. Contracts we reviewed showed hourly rates ranging from $9.86 to $30. Two of the VA medical facilities established rates on a per visit basis. We found facilities in high cost of living localities contracted for lower rates than facilities where the cost of living was low. The five VAMCs that obtained the best rates typically performed wide-ranging research into the H/HHA standard rates, and often utilized State Medicaid rates or Bureau of Labor Statistics rates for their localities during negotiations for services. We compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized, and found that 5 (31 percent) of the 16 sites, through their own initiative, considered State Medicaid rates in contracting for H/HHA services. We found that the 5 sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,850 in payments made for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we estimated that the program could avoid, on average, about $10.7 million in costs annually.

We found that 163 (24 percent) of the 667 veterans receiving H/HHA services during the first quarter of FY 2002 at 16 sites we visited also received basic special monthly compensation or pension (SMC/P) benefits from the Veterans Benefits Administration due to their need for aid and attendance (A&A). VHA program managers were unaware that 72 (44 percent) of those 163 veterans were receiving this benefit. At the same time, eight of the sites had about 107 other patients on waiting lists. We found nothing that precluded the consideration of the veteran's receipt of SMC/P benefits, along with other personal resources, prior to and during the authorization of H/HHA services. These benefits could help defray the cost of personal care services and allow a greater number of patients to be served by the H/HHA program.

We recommend that the Under Secretary for Health issue a policy replacing the expired VHA Directive 96-031 and provide additional guidance requiring that patients receive thorough initial interdisciplinary assessments prior to H/HHA Program placement. We also recommend that patients receiving H/HHA services meet clinical eligibility requirements, and that benchmark rates for these services are established. We further recommend that the Under Secretary seek General Counsel opinion on whether veterans' SMC/P status may be considered when prioritizing need for services and determining frequency of authorized visits. If General Counsel determines that this consideration is appropriate, the new policy should reflect this change.

The Under Secretary for Health (USH) concurred with the findings and recommendations, but he had expressed concerns that the initially estimated $11.4 million in better use of funds derived from the implementation of benchmarks needed to consider additional variables and planned program criteria changes in the future. We met again with VHA officials to resolve these concerns and as a result, reduced the estimated monetary benefits to $10.7 million. The USH provided acceptable improvement plans. We will follow-up until the planned actions are completed. The full text of his comments are shown in Appendix A. This report was prepared under the direction of Ms. Victoria Coates, Director, Atlanta Regional Office of Healthcare Inspections.

(original signed by:)

ALANSON J. SCHWEITZER
Assistant Inspector General for
Healthcare Inspections

INTRODUCTION

Purpose

The Department of Veterans Affairs Office of Inspector General's Office of Healthcare Inspections conducted an evaluation of the Veterans Health Administration Homemaker and Home Health Aide Program. The evaluation was conducted to determine whether H/HHA programs at VA medical facilities were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost effective, and met customer expectations.

Background

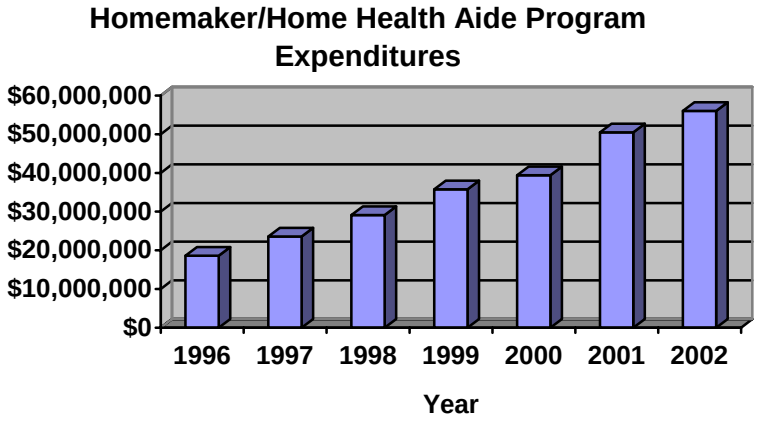
As of September 30, 2001, approximately 9.6 million veterans were age 65 or older and more than 600,000 of those veterans were age 85 or older.[1] A substantial number of these veterans have, or will have long-term care needs. The VA has recognized that home-based care is a vital component of an integrated health care delivery system, and is needed to meet the long-term care needs of our aging veterans. The H/HHA Program operates under the authority of Title 38 United States Code (USC) Section 1720C, which allows the Secretary to furnish home health services as necessary or appropriate for the effective and economical treatment of veterans.

VHA Directive 98-022 prescribes the implementation of several VHA programs created to meet the long-term care needs of veterans. One such activity discussed in this directive is the H/HHA Program. The program provides homemaker and home health aide visits to eligible patients in their homes and communities using contract nursing home funds. VA medical facility managers are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs. Expenditures for a patient receiving home health services cannot exceed 65 percent of the average VA nursing home per diem rate. This program is consistent with the *Veterans Millennium Health Care and Benefits Act* (the Millennium Act), Public Law 106-117, which promotes the provision of non-institutionalized health care in community settings.

VHA considers H/HHA services to be an alternative to nursing home care. When veterans are referred for these services, clinicians have judged that the veterans would, in the absence of H/HHA services, need nursing home care. The goal of providing these services is to prevent or delay institutional placement. The program provides H/HHA visits through CHAs to eligible beneficiaries using contract nursing home funds. Veterans enrolled in this program must be receiving primary health care from VHA and must meet clinical and administrative eligibility criteria.

[1] Department of Veterans Affairs FY 2001, Annual Accountability Report Statistical Appendix.

By the end of Fiscal Year (FY) 2001, 125 VA medical facilities were providing H/HHA services to about 8,645 veterans.[2] The following chart shows the increase in VA expenditures for providing H/HHA services since 1996:[3]



In 1993, VA conducted a pilot program to furnish personal care and health-related services in noninstitutional settings for certain eligible veterans. The program consisted of H/HHA services coordinated by VA staff. The H/HHA Evaluation Project was completed in June 1995.

The findings, published in the VA Guide To Long-Term Care Programs and Services, Volume 3, identified the following problems with the provision of services:

- Eleven percent of veterans expressed dissatisfaction with the continuity of care (frequent changes in care providers from the agency).

- The external regulation of contracted H/HHA vendors and their internal procedures for quality control and staff training varied.

- Lack of allotted staffing to administer the program was perceived by employees to adversely affect its implementation and management.

Additionally, a 1996 OIG audit found that $10.4 million was spent for 186,000 visits from aides or non-nursing personnel, at an average cost of $56 per visit.[4] The period reviewed for the 1996 report was April 1, 1994, through March 31, 1995.

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[2] General Accounting Office (GAO) letter report, VA Long-term Care: Implementation of Certain Millennium Act Provisions is Incomplete, and Availability of Noninstitutional Services is Uneven. (FAO-02-51OR; GAO File #4055F).

[3] Data taken from the KLF Menu Financial Management Service Reports.

[4] OIG Report entitled, "Internal Controls Over the Fee-Basis Program," Report Number 7R3-A05-099, dated June 20, 1997.

The OIG recommended that the Under Secretary for Health improve the cost effectiveness of home health services by:

- Establishing guidelines for contracting for the services.

- Providing contracting officers with benchmark rates for determining the reasonableness of charges.

The OIG's recently published semiannual report points out that VHA has yet to implement these recommendations.[5] VHA provided a draft directive to the OIG, in January 2001, to specifically address these recommendations. However, there was a lack of consensus from VHA field reviewers, and the OIG nonconcurred with the draft document. VHA withdrew the directive from concurrence in August 2001, to begin a complete revision. At the time of our evaluation, the VHA geriatrics and extended care staff was formulating a policy, and a directive may be drafted later in FY 2003. We are concerned that these 6-year-old recommendations have not been implemented and VHA is losing opportunities to save valuable resources that could be used to care for veterans.

Scope and Methodology

As part of the OIG's CAP reviews, we inspected H/HHA programs at 17 VA medical facilities between October 2001 and September 2002. We sampled 142 patients, at 16 sites, who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. We also consulted with OIG auditors who assisted us on the financial aspects of the review. Although the VHA Directive related to H/HHA Program operations expired in December 1997,[6] continued compliance is expected until a new policy is issued.

One of the 17 facilities we visited had no patients who met the selection criteria of receiving H/HHA services for at least 6 months. This facility limited contracts to 3 months to serve as many patients as possible. No data from the medical record reviews or the satisfaction survey of patients from this facility were included in this report; however, other program information was included.

We evaluated a larger sample of 667 patients (all patients receiving H/HHA services) from the 16 medical facilities to determine the SMC/P status of veterans receiving H/HHA services.

[5] OIG Semiannual Report to Congress, April 1, 2002 to September 30, 2002.
[6] VHA Directive 96-031.

We conducted the following reviews to determine whether the H/HHA programs were in compliance with VHA policy and if the services provided to veterans were clinically appropriate, cost effective, and met customer expectations:

- We reviewed local policies and interviewed H/HHA Program coordinators and team members from contracting, billing, nursing, and social work to assess their compliance with VHA directives.

- We reviewed CHAs' documentation regarding supervision and patient satisfaction, and performance improvement data to assess the quality of the H/HHA services provided to veteran patients.

- We reviewed the medical records of 142 patients receiving care at 16 medical facilities to evaluate initial interdisciplinary assessments, clinical eligibility, and re-certifications for continued services.

- We contacted 70 of the 142 patients in our sample, or their caregivers, to assess their satisfaction with H/HHA services. We recorded the perceptions of the patients or their caregivers regarding the timeliness of H/HHA services, the courtesy shown by homemakers or home health aides, and the levels of satisfaction with the program.

- We reviewed contractual agreements between the VA medical facilities and CHAs and examined the invoices for patients receiving services during the first quarter FY 2002, to determine whether the CHAs complied with authorized rates and hours, and whether VA medical facility managers appropriately monitored the billings. We also compared the authorized rates to the local State Medicaid rates and the Department of Labor's Bureau of Labor Statistics Wage Rates to determine the reasonableness of the charges. We examined invoices for 142 patients.

- We utilized the Benefits Delivery Network (BDN) to determine whether veterans receiving H/HHA services were also receiving SMC/P benefits because of the need for basic aid and attendance (A&A).[7] We obtained copies of the rating decisions for 32 patients who were receiving SMC/P benefits to determine whether the SMC/P was provided for the same reasons for which the patients were receiving H/HHA services. We also determined whether H/HHA Program managers were aware of their veterans' SMC/P status. We verified the SMC/P status of 667 veterans.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[7] In determining whether a veteran is in need of A&A, Veterans Benefits Administration adjudicators consider if the veteran's disabilities make it impossible to perform such basic functions of daily living as bathing, dressing, and eating without the assistance of another person.

RESULTS AND CONCLUSIONS

While we found deficiencies with patient selection and program management at some facilities we visited, patients generally told us they were satisfied with H/HHA services. We interviewed 70 patients or their caregivers from 16 facilities. All 70 respondents told us that their homemakers or home health aides came on the correct days and as often as scheduled. All 70 respondents said that their homemakers or home health aides treated them with courtesy. We found that 67 (96 percent) of the 70 respondents told us they would recommend the program to their family members. Of the 70 respondents interviewed, 68 (97 percent) rated their H/HHA services as good or very good.

We followed-up on three issues identified during the 1995 VHA evaluation project. We found that patient satisfaction with the continuity of care was unchanged from 1995. Our patient satisfaction survey revealed that 8 (11 percent) of 70 patients reported not getting the same homemakers or home health aides each visit. Program managers told us that the CHAs made every effort to provide patients with the same caregivers. This factor did not cause a significant negative impact on overall patient satisfaction.

Interviews conducted with 98 employees from 13 VA medical facilities during the 1995 VHA pilot program evaluation revealed that staff were concerned that CHAs' internal procedures for quality control and staff training varied. They also had concerns about the lack of program staffing. We found that 87.5 percent of the facility staff members we surveyed felt that there was consistency in quality control and staff training among the various CHAs that served their veterans. In addition, we asked program managers in 17 facilities if they felt that they had sufficient staff to effectively manage their programs. We found that 13 (76 percent) of 17 facilities' program managers believed the H/HHA programs were sufficiently staffed.

Issue 1: Clinical Eligibility and Waiting List Management

We found that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility. According to VHA Directive 96-031,[8] veterans eligible for H/HHA services are those who are in need of nursing home care. The phrase "…in need of nursing home care…" means that the patient's interdisciplinary team needs to make a clinical judgment as to whether such care is needed as defined by the following indicators:

- One or more activities of daily living (ADL) dependencies (bathing, dressing, toileting, transferring, or feeding); and

- Two or more of the following conditions:

    - Three or more instrumental activities of daily living (IADL) dependencies (shopping, meal preparation, light housekeeping, medication

[8] Purchase of Homemaker/Home Health Aide Services, April 16, 1996.

management, financial management, mobility [ability to leave home], using a telephone, and laundry);

- Current residence in (or recent discharge from) a nursing facility;
- 75 years old, or older;
- High use of medical services defined as 3 or more hospitalizations in the past year and/or utilization of outpatient clinics/emergency evaluation units 12 or more times in the past year;
- Clinical depression;
- Living alone in the community; or
- Significant cognitive impairment.

Clinical Eligibility

We found that 12 (8 percent) of 142 patients did not have any ADL dependencies documented in their initial assessments for H/HHA services yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, we found that 7 (10 percent) of the 70 respondents interviewed said that they would not be in need of nursing home placement at this time even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions.

In one VA medical facility, three patients receiving H/HHA services did not meet clinical eligibility requirements as none of them had documented ADL dependencies. The program coordinator told us that he interpreted VHA policy to mean that patients could qualify for H/HHA services if they had either ADL or IADL dependencies.

Those patients with no ADL dependencies received homemaker services only. Although one of the patients lived alone and was advanced in age, he told us he was able to drive himself around and did not need any assistance with ADLs. He told us he had a very active social life and we did not find any documented evidence of cognitive deficits or depression. This patient stated that the homemaker cleaned his carpets and took his clothing to the laundromat. He told us that even without the H/HHA services, he would not need nursing home placement at this point in his life.

Waiting Lists

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical

facilities visited had waiting lists for placements in their programs. One facility had 23 patients on its waiting list, with one patient waiting 6 months for services. Another facility had eight patients on a waiting list to receive H/HHA services, and one patient had been on the list for 8 months. Three ineligible patients were receiving services through this latter facility, and a fourth (eligible) patient had repeatedly requested to terminate or reduce the hours of homemaker service he was receiving as he felt he did not have enough tasks to "...keep the homemaker busy." All eight wait-listed patients met eligibility criteria and may have been in greater need than some of the patients currently enrolled in this facility's H/HHA Program.

Most facilities' managers did not consider a veteran's receipt of A&A benefits, which could defray the cost of personal care, when authorizing H/HHA services even when other patients were on waiting lists for placement in the programs. We found seven patients in programs with waiting lists who did not meet clinical eligibility criteria yet were receiving H/HHA services in addition to A&A benefits.

Issue 2: Initial Interdisciplinary Assessment for Referral

We did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed. VHA policy requires that a physician, nurse, and social worker, at a minimum, complete an interdisciplinary assessment of a patient's need for H/HHA services.

Of the 100 medical records that did contain interdisciplinary assessments, we did not find documentation of nursing participation in 29 (29 percent) initial assessments, nor did we find evidence of social work participation in 19 (19 percent) initial assessments. While physicians participated in the assessments in 74 (74 percent) of 100 assessments, we found that, for the most part, the physicians merely cosigned the referrals for services. Most in-depth documentation of patients' needs for services was left to nurses or social workers.

We concluded that VHA interdisciplinary teams and program managers needed to more thoroughly evaluate patients' clinical eligibility, considering that 14 percent of our patient sample did not meet VHA requirements.

Issue 3: Program Operations and Quality of Care

We found many areas wherein program managers did not comply with VHA policy. All but one VA medical facility had designated coordinators of the programs; however, 8 (47 percent) of 17 facilities did not have local oversight committees monitoring program operations or the quality of patient care.

VA policy requires that VHA employees reassess their patients' continued needs for services every 3 months. We found that only 8 (47 percent) of 17 VA medical facilities were performing these reassessments in the time frame prescribed. Timely reassessments are necessary to evaluate patients' continued needs for services, and to

reallocate resources to wait-listed patients whenever possible.

CHAs provided quarterly documentation of performance improvement activities to VA program managers in only 3 (18 percent) of 17 facilities visited. H/HHA Program managers cannot adequately monitor quality of care without reviewing CHAs' quality assurance measures and outcome data.

Although VHA policy requires that only licensed providers be utilized, we found that in six VA medical facilities visited, some unlicensed CHAs provided services to VA patients. This occurred mostly in localities with limited home health care resources, and usually applied to homemaker services only.

Issue 4: Cost Effectiveness

VHA has not established guidelines for contracting for H/HHA services or provided contracting officers with benchmark rates for determining the reasonableness of charges as recommended in our 1997 report. Contracts we reviewed showed hourly rates ranging from $9.86 to $30. Two of the VA medical facilities established rates on a per visit basis. We found facilities in high cost of living localities contracted for lower rates than facilities where the cost of living was low. The five VAMCs that obtained the best rates typically performed wide-ranging research into the H/HHA standard rates, and often utilized State Medicaid rates or Bureau of Labor Statistics rates for their localities during negotiations for services.[9]

From a sample of billings for 142 patients at 16 sites, we compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized. We also examined the invoices and payments for H/HHA services provided to the 142 patients in our sample during the first quarter of FY 2002, to determine whether the 16 facilities monitored billings for services provided within the scopes of the authorizations.

The following table reflects the extent of the authorizations, billings, and payments for the services provided during the first quarter of FY 2002 for the 142 patients in our sample:

Activity	Hours	Amount
Authorized Services	16,735	$300,169
Billed Services	14,130	$270,205
Payments	14,081	$265,849

We compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized, and found that 5 (31 percent) of the 16 sites, through their own initiative, considered State Medicaid rates in contracting for H/HHA services. We found that the 5 sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,850 in payments made

[9] Taking into consideration the localities.

for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we estimated that the program could avoid, on average, about $10.7 million in costs annually ($67.2 million x 16 percent), if the State Medicaid rates are used to develop benchmark rates.[10]

Overall, the VA medical facilities effectively monitored the bills for H/HHA services by requiring signed back-up documentation of the visits and comparing the billed rates and hours with the authorized services.[11] There were some isolated incidents wherein the facilities paid higher billed rates than the authorized rates, resulting in overpayments of $1,770 on behalf of 12 patients. Similarly, of the $265,849 the facilities paid, only $4,165 was for services that exceeded the authorized amounts. When patients did not receive all authorized services, documentation did not always reflect the reasons for the missed visits.

Issue 5: Consideration of Basic Special Monthly Compensation or Pension

The H/HHA Program authorized services for 667 patients totaling at least $1.4 million at 16 sites we visited during the first quarter of FY 2002. Of these 667 patients, 163 patients (24 percent) also received basic SMC/P from the Veterans Benefits Administration due to their need for aid and attendance. The amount of the SMC/P for these 163 patients totaled $242,269 during the period under review. VHA program managers were unaware that 72 (44 percent) of the 163 patients were also receiving SMC/P totaling about $99,300. The program managers at these sites authorized at least $160,500 in H/HHA services for these 72 veterans during the first quarter of FY 2002. At the same time, eight of the sites had about 107 other patients on waiting lists.

We found that program managers had differing opinions, and had been provided conflicting instructions, as to whether a veteran's SMC/P should be considered in the authorization of H/HHA services. We found nothing that precluded the consideration of the veteran's receipt of SMC/P benefits, along with other personal resources, prior to and during the authorization of H/HHA services; however, a General Counsel opinion should be sought to make a final determination on the appropriateness of this consideration. These benefits could help defray the cost of personal care services and allow a greater number of patients to be served by the H/HHA program.

Conclusions

Fourteen percent of the patients receiving H/HHA services in our sample did not meet clinical eligibility requirements. Some patients were not in need of nursing home care, while others only needed supervision with, but were not dependent in ADLs. Program managers interpreted eligibility criteria for H/HHA services differently.

[10] The $67.2 million projection was based upon the average annual increase of expenditures during the past six years.

[11] The patients, or their primary caregivers, typically signed documents attesting that the homemakers or home health aides performed the services at specified times.

Initial assessments by clinicians were often no more than referrals to the H/HHA Programs. The assessments rarely included documentation of actual evaluations by all required interdisciplinary team members and did not thoroughly document patients' disabilities, dependencies, and needs for services.

Some facilities had many patients on waiting lists and did not always consider clinical eligibility or patients' needs. Programs with scarce resources and wait-listed patients cannot afford to serve ineligible patients or patients not requiring these services.

To enhance controls, VHA managers need to issue policy for the provision and acquisition of H/HHA services to improve the quality of care and to maximize the use of resources. This policy should address assessment and monitoring of needs, including consideration of the patient's clinical eligibility and, if General Counsel determines it is appropriate, SMC/P status. VHA managers also need to establish a method of benchmarking rates for the acquisition of H/HHA services. Had benchmark rates been established as recommended, the H/HHA program could have, on average, freed about $10.7 million annually to treat additional patients.

RECOMMENDATIONS AND COMMENTS

We recommend that the USH:

a. Issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that:

    1. Patients receive thorough initial interdisciplinary assessments prior to placement in the program.

    2. Patients receiving H/HHA services meet clinical eligibility requirements.

    3. Benchmark rates for these services are established.

b. Seek a General Counsel opinion as to whether a veteran's SMC/P status can be considered when prioritizing need for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, we recommend that policy reflect this change.

Under Secretary for Health Comments

The USH agreed with the report's findings and concurred with the recommendations, but he expressed concerns about the monetary benefits that will be derived from implementing new policies and procedures. The USH stated that VHA program officials will follow-up with field staffs to ensure all assessment standards are accomplished and will send follow-up reminders. VHA officials plan to revise policies and procedures and issue written direction on benchmark rates by March 31, 2004. The USH also agreed to seek a General Counsel opinion in response to recommendation (b) in the report. The full text of his comments are shown in Appendix A.

Inspector General Comments

The USH concurred with the findings and recommendations and provided action plans that met the intent of our recommendations. While VHA program officials expressed concern that the estimated monetary benefits of $11.4 million might actually be lower, they could not provide us with an alternative approximation of the benefits that will be saved. They also acknowledged that implementing new policies and procedures and benchmark rates may actually increase economies beyond the estimate. We met with VHA program officials in September 2003 to further discuss their concerns on our calculations. Based on the discussion at this meeting, and efforts to acknowledge additional VHA factors that might influence savings, we lowered the estimate to $10.7 million. Despite these efforts, VHA officials preferred to first implement their action plans and then measure actual data to determine the extent of the funds that could be put to better use. We will continue to follow-up until all action plans are implemented and VHA completes an after action review.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs **Memorandum**

Date: Sep 25 2003

From: Under Secretary for Health (10/10B5)

Subj: OIG Draft Audit Report, *Homemaker/Home Health Aide (H/HHA) Services*, Project Number 2002-00124-HI-0041, (EDMS Folder 232193)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The appropriate program offices have reviewed this draft report. We agree with the report's findings and concur with the report's recommendations with the exception of the monetary benefits. We believe the estimated savings calculated by OIG for what will be derived from the implementation of reasonable charges in this program is somewhat high ($11.4 million annually), however an alternative estimated monetary benefits cannot be provided at this time. Representatives from your office met with VHA representatives on August 27, 2003 to discuss VHA concerns related to your estimate. At that meeting, VHA representatives explained that to ensure that the program best addresses the needs of our veteran population, VHA has changed program criteria for its Homemaker/Home Health Aide programs since this review was conducted. The new criteria require that all eligible candidates for the program have at least three activities of daily living (ADL) or have significant cognitive impairment to be admitted to the program. This change in the level of services for patients admitted to the program will reduce the savings projected; however, we will not know the extent of the effect until we have sufficient actual data.

2. VHA has already initiated several actions we believe will address the majority of the cited issues. For example, VHA's Geriatrics & Extended Care (G & E) Strategic Healthcare Group used its July 2003 National Conference call on contract care to review the initial assessment standard, with follow-up reminders to be provided in writing to the networks by September 30, 2003. VHA is currently completing a project to provide written direction on H/HHA rates in response to an earlier audit and will complete this project at the end of FY 2003, with an estimated publishing date of March 31, 2004.

3. Regarding recommendation b, that indicates VHA should seek a General Counsel (GC) opinion as to whether a veteran's special monthly compensation or pension status (SMC/P) can be considered when prioritizing the need for services and frequency of authorized H/HHA visits, G &E discussed this with the GC in August 2003. At that discussion, it was determined that a

1997 General Counsel opinion does not speak directly to this recommendation. G &E therefore is now in the process of seeking General Counsel's opinion on this issue.

5. An action plan detailing our response to the recommendations is attached. Thank you for this opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 273-8360.

(original signed by:)
Robert H. Roswell, MD

Attachment

Recommendation: #a1. The Under Secretary of Health will issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that patients receive thorough initial interdisciplinary assessments prior to placement in the program. **VHA concurs.**		**Recommendation Metrics: % of achievement of accomplishing an action within specified timeframes.** Green= 80 to 100% 1 to 30 days of specified timeframe Yellow= 60 to 79% 31 to 60 days within timeframe. Red= 59 to 0% 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improved Compliance with Standard for Initial Interdisciplinary Assessment of patients prior to H/HHA placement. VHA Objective 1.3*[1]	Hold a national conference call highlighting OIG findings and VHA's assessment standard. Provide written follow-up to VAMCs	Call will be held as scheduled.	30 Jul 03	Green Written information is in development	Call was held 1 Jul 03. .		
Directive & Handbook VHA Objective 1.3	Complete H/HHA Directive and Handbook, available for review and comment end of FY 2003, with an estimated publishing date of 30 Sept 05. Contains policy direction including, on assessment/ reassessment and clinical admission criteria		30 Sep 03 completion date. 30 Sept 05 Publication Date.	Green			
Initial Assessment VHA Objective 1.3	Introduce new Geriatrics & Extended Care (G&EC) Referral Form, with its use to commence 1st quarter, FY 04. G&EC will compare the referral form use and H/HHA program workload to ensure H/HHA benchmark is being met.	Ratio of G&EC Referral/Reassessment Form to H/HHA workload.	31 Oct 03 Introduction Date Mar 31 04	Green			

[1] *(VHA Objective1.3. Provide high quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost and those statutorily eligible for care).

Recommendation: **#a2**. The Under Secretary of Health will issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that patients receiving H/HHA services meet clinical eligibility requirements. **VHA concurs.**		**Recommendation Metrics: % of achievement of accomplishing an action within specified timeframes.** Green= 80 to 100% 1 to 30 days of specified timeframe Yellow= 60 to 79% 31 to 60 days within timeframe. **Red= 59 to 0% 61 days or more within timeframe.**					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improved Compliance with Clinical Admission Criteria. VHA Objective 1.3	Improve Compliance of patients meeting clinical admission criteria	Number of patients meeting admission criteria/number of admissions	2 quarters following publication of Handbook. 90% of admissions met admission guidelines	Green			
Recommendation 3a. Issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that benchmark rates for these services are established. VHA concurs		**Recommendation Metrics:% of achievement of accomplishing an action within specified timeframes.** Green= 80 to100% 1 to 30 days of specified timeframe Yellow= 60 to 79%< 31 to 60 days within timeframe Red= 59to 0% > 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improve Cost Effectiveness by providing policy direction on H/HHA rates. VHA Objective 3.1	Complete Guidance on rates for H/HHA. Rates reflect a blend of Medicare & Medicaid rates; comparison of VA rates to Medicare/Medicaid rates, by State.	G & E will compare Medicare/Medicaid benchmark rates to actual rates of VAMCs on a quarterly basis VA rates will be less than Medicare rates for H/HHA Medicare eligibles by EOFY 2004 .	Completion date: 30 Jul 03. Publication estimate- 30 July 05 90% compliance will benchmark rates by 1 Oct 05.	Green			

Recommendation 3b. Seek a General Counsel Opinion as to whether a veteran's SMC/P status can be considered when prioritizing for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, policy will be modified to reflect this change. VHA concurs.		**Recommendation Metrics:% of achievement of accomplishing an action within specified timeframes.** Green= 80 to100% 1 to 30 days of specified timeframe Yellow= 60 to 79%< 31 to 60 days within timeframe Red= 59 to 0% > 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Determine if a veteran's SMC/P status can be considered as recommended by OIG, in order to achieve VHA. Objective 1.3.	Seek General Counsel opinion on AID &Attendance benefits in H/HHA. Use General Counsel findings in Directive & Handbook, if appropriate.		30 Jul 03 30 July 05-target for A & A section to be added to the Handbook, if appropriate.	Green			

MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS

Report Title: Healthcare Inspection - Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program

Report Number: 02-00124-48

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
1c	Establish benchmark rates	$10,700,000	
Total		$10,700,000[1]	

[1] Annualized estimated savings based upon projected fiscal year 2003 expenditures.

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