DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement

AUDIT | REPORT #18-04924-112 | JULY 25, 2019

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Executive Summary

The Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program) pays monthly stipends to designated primary family caregivers (caregivers) of seriously injured veterans whose medical conditions occurred during or were made worse by military service on or after September 11, 2001.[1] The program is run by caregiver support coordinators (CSCs) across 140 medical facilities, who are responsible for coordinating with VA clinicians to monitor veterans' well-being and the level of care provided. The VA Office of Inspector General (OIG) conducted this audit involving about 19,800 veterans enrolled in the program at some time from May 1, 2011, to April 30, 2018. This audit determined if the Veterans Health Administration (VHA) took timely and consistent action to discharge veterans and their caregivers from the Family Caregiver Program and subsequently canceled caregiver stipends following a veteran's or caregiver's death, or veteran incarceration or hospitalization.[2] VHA program guidance does not address what should happen when caregivers are incarcerated or hospitalized. The audit team also did not identify from available data any cases when a caregiver was hospitalized or incarcerated.

The audit team focused on discharges and related monthly stipend cancellations because delays in these actions can result in improper payments. The financial risks to VHA are significant because the program is expanding eligibility to all-era veterans and their caregivers, which is expected to start in fiscal year (FY) 2019. According to the Congressional Budget Office, these legislative changes will add approximately 60,200 veterans to the program at a cost of about $1.6 billion in additional caregiver stipends from FY 2019 through FY 2023.[3]

The audit team also addressed an OIG Hotline allegation as it conducted its oversight work. The complainant alleged that a caregiver was inappropriately paid for nearly three years after the veteran died because a CSC at a VA medical facility did not take timely action to discharge the veteran and caregiver from the program.[4]

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[1] 38 Code of Federal Regulations, Part 71, *Interim Final Rule*, May 5, 2011. At the time of the audit, program eligibility was limited to post-September 11, 2001, veterans, but is expected to start expanding in FY 2019, pending the implementation of an information technology system that fully supports program expansion.

[2] Throughout this report, the term "discharge" is used to describe VHA's revocation of veterans' program eligibility (or the eligibility of their caregivers) for no longer meeting program requirements.

[3] Congressional Budget Office Cost Estimate, *H.R. 5674 VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act), May 14, 2018.

[4] The audit team did not include the name of the VA medical facility referenced in the OIG Hotline allegation for privacy reasons.

What the Audit Found

VHA nearly always took timely action to discharge veterans and caregivers from the Family Caregiver Program following the veteran's or caregiver's death, or veteran incarceration or hospitalization and then canceled the caregiver stipends. CSCs did not discharge veterans and caregivers within required time frames in only about six percent of the cases the audit team reviewed. While infrequent, these delayed discharges caused VHA to pay at least $356,000 in improper and questionable caregiver stipends.[5] If program controls are not improved, VHA could pay an estimated $583,000 over five years in improper stipends when a veteran or caregiver dies.[6]

The OIG identified a number of opportunities for VHA to improve Family Caregiver Program controls and procedures. At the time of this audit, CSCs could not systematically identify deceased, imprisoned, or hospitalized veterans or caregivers. The program's information system in use—the Caregiver Application Tracker—lacks the capability to consistently match veteran or caregiver personal information against VA death, incarceration, and hospitalization data. VHA started developing the Caregiver Tool as a replacement for the Caregiver Application Tracker. The audit team observed a demonstration of the Caregiver Tool and observed the system's capability to integrate with VA's death data to identify deceased program participants. The Caregiver Tool, however, did not have the capability to identify incarcerated or hospitalized veterans or caregivers. In June 2018, the "VA MISSION Act of 2018" (Public Law 115-182) required VA to implement an information technology system to support the Family Caregiver Program and have capabilities for data assessment and comprehensive monitoring of the program and integrate with other VHA information systems.[7] VHA reported that it halted its efforts in April 2019 to continue developing the Caregiver Tool data system. Rather than continuing to develop the Caregiver Tool, VA Office of Information and Technology officials reported that VA was developing the Caregiver Record Management Application—a new system to meet

[5] The OIG used the term "at least" to describe the amount of questionable caregiver stipends that were made when veterans or caregivers died, or veterans were incarcerated or hospitalized for more than six months, because the audit team was not able to identify all program participants who experienced these events. The amount of $356,000 is rounded to reflect the total estimated improper and questionable caregiver stipends VHA made from May 2011 through April 2018. According to the Office of Management and Budget Circular A-123, Appendix C, Part I-A(1), *Requirements for Payment Integrity Improvement*, June 26, 2018, "an improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." The OIG uses the term "questioned cost" when a cost is not supported by adequate documentation. Appendix C details the team's monetary benefits calculations.

[6] This number is rounded. Appendix B details the audit team's methodology to estimate future caregiver stipend errors in the event of a veteran or caregiver death. Appendix C details the team's monetary benefits calculations.

[7] Public Law 115-182, *John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act), § 162.

MISSION Act requirements. According to VA Office of Information and Technology officials, this new system should be in testing by early FY 2020.

Currently, CSCs must rely on information collected by clinicians during quarterly monitoring sessions with veterans and caregivers, or that is otherwise reported to them to identify changes in their status. Monitoring was not always a reliable way to identify changes as reported in the OIG's prior *Audit of the Program of Comprehensive Assistance for Family Caregivers*. According to that report, CSCs did not identify changes in veteran and caregiver conditions because required monitoring did not occur in a timely manner or consistently.[8] The National Caregiver Support Program (CSP) Office, which oversees the program, should better leverage available VA data sources to identify these veterans and caregivers to ensure that they are discharged appropriately, and the risk of improper payments is minimized.

VHA should also take steps to better inform veterans and caregivers of their responsibility to promptly notify their local CSC when a program participant dies. VHA's current *Roles, Responsibilities and Requirements for The Program of Comprehensive Assistance for Family Caregivers* is incomplete because it does not address to whom and when veterans and caregivers should notify a CSC of a death.[9]

National CSP Office personnel admitted they did not fully consider how incarceration of either a veteran or caregiver could affect program eligibility. While caregiver stipends are not disability benefits like those paid to veterans with service-connected injuries, the National CSP Office should consider that federal law requires the Veterans Benefits Administration to reduce disability benefits for incarcerated veterans.[10] Similarly, program guidance lacks a process for the veteran to reapply for the program following a discharge that occurred because of the veteran's or their caregiver's incarceration or hospitalization. According to the National CSP director, veterans and their caregivers must restart the entire program enrollment process even in cases when the veteran's health, need for a caregiver, and caregiver designation have not changed. There is also no option for CSCs to suspend program enrollment for veterans and caregivers during an incarceration or hospitalization so that services can be restarted quickly.

VHA Paid a Deceased Veteran's Caregiver for Nearly Three Years

The audit team substantiated the allegation that VHA improperly paid about $71,000 to a deceased veteran's caregiver because a CSC did not take timely action to discharge the veteran

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

[9] VA Caregiver Support, *Roles, Responsibilities and Requirements for The Program of Comprehensive Assistance for Family Caregivers*, July 2017.

[10] United States Code: Title 38, Part III, Chapter 15, § 1505.(a) and Part IV, Chapter 53, § 5313.(a)1.

and initiate cancellation of the caregiver stipend.[11] The CSC's inaction went undetected because the medical facility referenced in the OIG Hotline allegation lacked procedures to ensure that CSCs took timely action to (1) address changes in the program participants' status following a death and (2) initiate actions to stop caregiver payments. The facility's chief of staff, social work chief, and social work program coordinator also did not ensure veterans and caregivers were regularly monitored, as required.

What the OIG Recommended

The OIG recommended the Under Secretary for Health conduct the following:[12]

- Establish processes to conduct matching, at least quarterly, of the records of enrolled veterans and their caregivers against VA's death, incarceration, and hospitalization data to help ensure timely program discharges and to reduce the risk of improper and questionable payments.
- Outline in the program's roles and responsibilities document what the veteran and caregiver responsibilities are for promptly notifying CSCs of deaths.
- Institute a program working group to clarify inconsistencies and gaps in program guidance. Specifically, the working group should determine if incarcerated or hospitalized veterans or caregivers should adhere to different discharge requirements. The working group should also consider the time frames for discharges, a process for veterans and caregivers to reapply to or be suspended from the program following a discharge due to incarceration or hospitalization, and should initiate updating program guidance accordingly.

Management Comments

The Under Secretary for Health concurred in principle with Recommendation 1 and concurred with Recommendations 2 and 3 of the report. The Under Secretary for Health's planned corrective actions are largely responsive to the recommendations and should address almost all the issues identified in the report. While VHA addressed data matching to identify deceased veterans and their caregivers, it did not fully address recommended data matching to identify incarcerated or hospitalized program participants. However, VHA reported it will assess the feasibility for obtaining and integrating available data on veteran and caregiver deaths, incarcerations, and hospitalizations into the program information system that is under

[11] This is a rounded number. This amount is included in the audit team's total estimate of the $356,000 that VHA made in improper and questionable caregiver stipends from May 2011 through April 2018. Appendix C details the team's monetary benefits calculations.

[12] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary.

development and expected to be deployed by June 2020. VHA will report the results of this assessment. These planned actions meet the intent of the recommendation. The OIG will monitor VHA's progress on proposed actions until the intent of the recommendations is addressed and will then close them. The Under Secretary for Health also provided limited technical comments, which the OIG incorporated in the report, as appropriate.

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Contents

Abbreviations

CAT	Caregiver Application Tracker
CSC	caregiver support coordinator
CSP	Caregiver Support Program
FY	fiscal year
OCC	Office of Community Care
OIG	Office of Inspector General
SSA	Social Security Administration
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted this audit to determine if the Veterans Health Administration (VHA) took timely and consistent action to discharge veterans and designated primary family caregivers (caregivers) from the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program) and subsequently cancel caregiver stipend payments following a veteran's or caregiver's death, or veteran incarceration or hospitalization. The audit team also examined an allegation reported to the OIG Hotline that after a veteran died, the caregiver was inappropriately paid for nearly three more years because a caregiver support coordinator (CSC) at a VA medical facility referenced in the allegation did not act during that time to discharge the veteran and his caregiver.[13]

Family Caregiver Program

Initially, Congress established the Family Caregiver Program to assist caregivers of post-September 11, 2001, veterans and to improve their healthcare services.[14] The program provides training, counseling, mental health services, respite care, and a monthly stipend to a veteran's caregiver.[15] Caregivers of these veterans are also eligible for health insurance benefits through the VA's Civilian Health and Medical Program if not covered by another healthcare plan.[16]

In June 2018, the "VA MISSION Act of 2018" was enacted, which expanded the Family Caregiver Program to eligible veterans of all eras. However, the law requires VA to implement an information technology system that fully supports the program and allows for data assessment and comprehensive monitoring of the program prior to accepting applications from all-era veterans. The program will expand eligibility to caregivers and veterans in two stages: (1) veterans injured on or before May 7, 1975, may apply for the program beginning in fiscal year (FY) 2019; and (2) veterans injured after May 7, 1975, and before September 11, 2001, may apply for the program two years later.[17] The expansion of the program puts additional stresses on VHA to ensure it identifies deaths, incarcerations, and hospitalizations to avoid improper payments.

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[13] The audit team did not include the name of the VA medical facility referenced in the OIG Hotline allegation for privacy reasons.

[14] Public Law 111-163, *Caregivers and Veterans Omnibus Health Services Act of 2010*, May 5, 2010.

[15] Public Law 111-163, Title I, § 1720G.(a) and § 1720G.(3)(A).

[16] VHA Directive 1152, *Caregiver Support Program,* June 14, 2017, Sections 2.a.(1) and 6.d.(3).

[17] Public Law 115-182, *John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act), §§ 161-163.

Veteran and Caregiver Eligibility for the Family Caregiver Program

Veterans must meet seven primary requirements to participate in the Family Caregiver Program, which are described in the following table.[18]

Table 1. Veteran Eligibility Requirements for the Family Caregiver Program

Primary requirement	Requirement description
1.	The individual is either a veteran or a member of the Armed Forces found unfit for duty due to a medical condition and has been issued a date for medical discharge.
2.	The individual has a serious injury, including traumatic brain injury, psychological trauma, or another mental disorder, incurred or aggravated in the line of duty in the active military, naval, or air services on or after September 11, 2001.*
3.	Such serious injury renders the individual in need of personal care services from another individual (a caregiver) for a minimum of six continuous months based on any one of the following: an inability to perform one or more activities of daily living; need for supervision or protection based on symptoms; or residuals of neurological or another impairment or injury.
4.	A clinical determination has been made that it is in the best interest of the individual to participate in the program.
5.	Personal care services that would be provided by the family caregiver will not be simultaneously and regularly provided by or through another individual or entity.
6.	The individual agrees to receive care at home after VA designates a family caregiver.
7.	The individual agrees to receive ongoing care from a primary care team after VA designates a family caregiver.

Source: 38 Code of Federal Regulations, Part 71, Final Rule
** The VA MISSION Act of 2018 expanded the Family Caregiver Program to eligible veterans of all eras. This is expected to start in FY 2019.*

Primary family caregivers must be at least 18 years of age. Applicants must also be either the veteran's spouse, son, daughter, parent, step-family member, or extended family member, or someone who lives with the veteran full time or will do so if designated as a family caregiver.[19]

[18] At the time of this audit, these requirements and others guiding the program were documented in the following authorities: 38 Code of Federal Regulations, Part 71, *Interim Final Rule*, May 5, 2011; 38 Code of Federal Regulations, Part 71, *Final Rule*, January 9, 2015; draft VHA *Caregiver Support Program Guidebook,* issued on April 20, 2012, updated on June 11, 2013, and updated and issued again on April 17, 2015; and VHA Directive 1152.

[19] 38 Code of Federal Regulations § 71.25, *Approval and Designation of Primary and Secondary Family Caregivers*, (b)(1) and (2).

Family Caregiver Program Stipends

VHA pays a monthly stipend to the caregiver. VHA's Office of Community Care (OCC) calculates the amount of the caregiver's stipend based on the level of care, or tier, the veteran requires, and on the Bureau of Labor Statistics' hourly seventy-fifth percentile wage rates for a home health aide within the veteran's geographic location.

- Tier 1: corresponds to 10 hours of care per week
- Tier 2: corresponds to 25 hours of care per week
- Tier 3: corresponds to 40 hours of care per week[20]

In November 2018, VA reported being in the process of drafting regulatory changes for the Family Caregiver Program. According to the National Caregiver Support Program (CSP) director, one policy consideration included simplifying the caregiver stipend determination process by using the Office of Personnel Management's General Schedule hourly wage rate at the Grade 5, Step 5 level in the eligible veteran's geographic area of residence. This rate would be consistent with the pay for a home health aide or nursing assistant. In the early stages of development, this proposed regulatory change would be subject to public comment and rulemaking. VHA did not have a completion timeline.

Family Caregiver Program Monitoring

VHA clinicians are required to conduct quarterly and annual in-home monitoring sessions of veterans and their caregivers. This monitoring can occur either in person or by telehealth or telephone calls. CSCs are responsible for coordinating with these clinicians to ensure veterans and caregivers are monitored every 90 days. The veteran's well-being—as well as the care and supervision the caregiver is providing—should be evaluated during these monitoring sessions to determine if the veteran's need for assistance with personal care services has changed.[21]

Program Discharge and Stipend Cancellation

CSCs are responsible for discharging veterans or caregivers after a death, incarceration, or hospitalization—in addition to other discharge reasons included in the following table—and

[20] 38 Code of Federal Regulations § 71.15 describes stipends as the hourly wage rate for home health aides at the seventy-fifth percentile in the eligible veteran's geographic area of residence, multiplied by the Consumer Price Index for All Urban Consumers (CPI-U). VHA's draft *Caregiver Support Program Guidebook,* Section C., *Stipend Payments,* April 20, 2012, provides tier descriptions.

[21] 38 Code of Federal Regulations § 71.40, *Caregiver Benefits*, (b)(2), and VHA Directive 1152, Sections 5.j(1) and c.(5).

reporting the discharge to OCC.[22] In turn, OCC is responsible for stipend cancellations. OCC personnel are also responsible for recovering stipends paid in error. The timing for discharging veterans and their caregivers, as well as related stipend cancellations, depends on the nature of the program discharge (see Table 2).

Table 2. Family Caregiver Program Discharge Requirements and Stipend Cancellation Timing

Nature of discharge	Discharge requirement	Stipend cancellation
Veteran or caregiver no longer meet primary program eligibility requirements (to include "for cause"* and "noncompliance")	Immediate	Immediate
Veteran's death	Date of death	Extended for 90 days after the veteran's date of death
Caregiver's death	Date of death	Immediate
Veteran institutionalized (admitted to or living in a setting other than their home, such as hospital, nursing home, inpatient treatment program, jail or incarceration)	Date it becomes known that the length of stay is expected to last longer than six months with no expectation of returning home	Extended for 90 days from the date the veteran is discharged from the program
Veteran or surrogate request	Present or future date requested by veteran or surrogate	Extended for 30 days after the date of discharge
Caregiver request	Present or future date requested by caregiver	Until the date of discharge
Veterans no longer clinically eligible	Date VA makes the clinical determination	Extended for 90 days after the clinical determination date

Source: OIG analysis of VHA Directive 1152; Caregiver Support Program Standard Operating Procedure, Revocation for Institutionalization and Incarceration; and Caregiver Support Program, Caregiver Application Tracker User Manual Caregiver Application Tracker

** The discharge category "for cause" can include veterans who were discharged from the program because facility personnel determined that the caregiver relationship was not in the veteran's best interest.*

[22] Throughout this report, the term "discharge" is used to describe VHA's revocation of veterans' program eligibility (or the eligibility of their caregivers) for no longer meeting program requirements. In addition, the audit team analyzed death data for both veterans and caregivers.

Family Caregiver Program Data System

CSCs use the Caregiver Application Tracker (CAT) to administer the program. OCC personnel use CAT and a Microsoft Access Database to process and terminate stipends. The limitations of CAT are discussed throughout the report.

Results and Recommendations

Finding 1: VHA Discharged Veterans and Caregivers within Time Requirements, but Can Improve Program Controls

Overall, VHA almost always took timely action to discharge veterans and caregivers from the Family Caregiver Program following a veteran or caregiver death, or veteran incarceration or hospitalization. The same can be said for VHA cancelling related stipends. From May 2011 through April 2018, VHA discharged 94 percent (588 of 626) of the ineligible program participants reviewed, as required. Weaknesses in program controls, however, resulted in VHA making at least $356,000 in improper and questionable caregiver monthly stipends for the remaining 6 percent of ineligible program participants over that time period.[23] The audit team did not identify indicators that VHA made these errors in payment because of potential veteran or caregiver fraud. Nonetheless, opportunities exist for VHA to strengthen program oversight to consistently achieve discharge timeliness and reduce the risk of making improper and questionable payments as the program faces explosive growth. To address these weaknesses, VHA should develop

- Standard processes and systems to identify veteran and caregiver deaths, incarcerations, or hospitalizations; and
- Consistent program guidance that clearly defines institutionalizations (such as incarcerations and hospitalizations) for both veterans and caregivers and includes time frames for how long they can remain institutionalized before being discharged from the program.

Failure to tighten controls can significantly increase the financial risks to VA when the program starts to expand to all-era veterans. The Congressional Budget Office has estimated that about

[23] The OIG used the term "at least" to describe the amount of questionable caregiver stipends that were made when veterans or caregivers died, or veterans were incarcerated or hospitalized for more than six months, because the audit team was not able to identify all program participants who experienced these events. A conservative estimate was used to describe the amount of questionable (the OIG uses the term "questioned cost" when a cost is not supported by adequate documentation) caregiver stipends made when veterans were incarcerated or hospitalized. The estimated $356,000 reflects the total approximated improper and questionable caregiver stipends that VHA made from May 2011 through April 2018. This total was calculated by summing $241,782 (improper costs associated with caregiver or veteran deaths) with $114,334 ($36,356 in questioned costs associated with incarcerations plus $77,978 in questioned costs for the hospitalization sample). Because of rounding, the total will not reflect the sum of the individual amounts (also, $36,356 is rounded elsewhere in text to $36,400; and $77,978 is rounded to $78,000). According to the Office of Management and Budget Circular A-123, Appendix C, Part I-A(1), *Requirements for Payment Integrity Improvement*, June 26, 2018, "an improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Appendix C details the team's monetary benefits calculations.

60,200 veterans—in addition to about 19,800 veterans already enrolled as of September 2018—will participate in the Family Caregiver Program from FY 2019 through FY 2023 at a cost of approximately $1.6 billion in additional caregiver stipends.[24] Improving program controls will reduce VHA's risk of paying improper and questionable caregiver stipends. If VHA continues to make errors at the same rate without making the necessary changes, VHA would incur an estimated $583,000 in improper payments when a veteran or caregiver dies over the next five years.[25]

What the OIG Did

The scope of the audit included about 19,800 veterans enrolled in, or discharged from, the Family Caregiver Program at some time from May 1, 2011, through April 30, 2018. The audit team focused on program discharges and caregiver stipend cancellations because delays in these actions expose the Family Caregiver Program to financial risks. To identify program participants who were deceased, incarcerated, or hospitalized, the team matched veteran and caregiver data with the following:

1. Social Security Administration (SSA) death file
2. State and federal incarceration data
3. VHA hospitalization data

Based on the available data, the audit team did not identify any cases when a caregiver was hospitalized or incarcerated. The team reviewed a total of 682 records that included all 572 deceased veterans and caregivers identified through the SSA death file; all 80 incarcerated veterans identified through state and federal incarceration records; and a judgmental sample of 30 veterans who were identified as being hospitalized through VHA hospitalization data. The team did not review enough hospitalized veterans to be representative of the entire population. Of the 682 records, the team assessed how CSCs applied discharge criteria. The team determined 56 incarcerated and hospitalized veterans did not meet discharge requirements and appropriately remained enrolled in the program. The team assessed the appropriateness of VHA's actions for the remaining 626 veterans.

The audit team interviewed National CSP Office and OCC officials and contacted CSCs and program officials from 19 VA medical facilities to learn how they applied discharge procedures when a veteran or caregiver died, or a veteran was incarcerated or hospitalized. Appendix B provides additional details on the audit scope and methodology.

[24] Congressional Budget Office Cost Estimate, *H.R. 5674 VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act), May 14, 2018.

[25] Appendix B describes how the audit team estimated improper payments related to future veteran and caregiver deaths. Appendix C details the team's monetary benefits calculations.

In the following sections, three factors associated with Finding 1 are discussed:

- Timeliness of veteran and caregiver discharges
- Timeliness of canceled stipends
- Controls to reduce the risk of future errors

Timeliness of Veteran and Caregiver Discharges

Of the cases the OIG examined, VHA took timely action to discharge 94 percent (588 of 626) of veterans and caregivers from the program following a veteran or caregiver death, or veteran incarceration or hospitalization. However, VHA made improper and questionable caregiver payments in 6 percent (38 of 626) of the cases reviewed by the audit team. Table 3 details the results of the review of all 626 cases.

Table 3. Timeliness of Program Participant Discharges

Nature of discharge	Number of participants who did not meet the discharge criteria and remained enrolled	Number of participants who did meet discharge criteria	Number of timely discharges	Number of delayed discharges	Percent of timely discharges
Veteran or Caregiver Death	--	572	541	31	95%
Veteran Incarceration	44	36	33	3	92%
Veteran Hospitalization	12	18	14	4	78%
Total	**56***	**626**	**588**	**38****	**94%**

Source: OIG analysis of a comparison of CAT and computerized veteran health records to the SSA death file, state and federal incarceration records, and VHA hospitalization data from May 2011 through April 2018
**These veterans had not been hospitalized or incarcerated long enough at the time of the audit team's review to warrant discharge from the Family Caregiver Program.*
***The team considered the discharges of four of these veterans delayed—one who was incarcerated and three who were hospitalized—because they and their caregivers had not yet been discharged from the program, as required, at the time of the team's review.*

Table 3 includes 56 veterans who, at the time of the audit team's work, were enrolled in the program. The team determined CSCs appropriately did not discharge these veterans from the program because they had not been incarcerated or hospitalized more than six months.

Discharges of Veterans and Caregivers Following Death

CSCs almost always took timely action to discharge the veterans and caregivers who died while enrolled in the Family Caregiver Program. However, in about 5 percent (31 of 572) of the cases reviewed, CSCs took longer than 90 days to identify the deaths and discharge veterans or caregivers from the program. As a result, VHA paid about $208,200 in improper payments to caregivers.[26]

According to program guidance, CSCs should immediately discharge veterans and caregivers from the program following a death. Furthermore, VA guidance and VHA Directive 1152 require OCC to stop caregiver stipends 90 days after the death of a veteran and immediately after the death of a caregiver.[27] Given the circumstances of a death and a reliance on the caregiver or veteran to make the CSC aware of the death, the audit team acknowledged that immediate discharge was not realistic to assess timeliness. Therefore, the team considered discharges to be delayed if the discharge occurred more than three months after a veteran or caregiver death because CSCs are required to monitor veterans and caregivers quarterly. The following figure details the timeliness of discharge after a veteran or caregiver death.

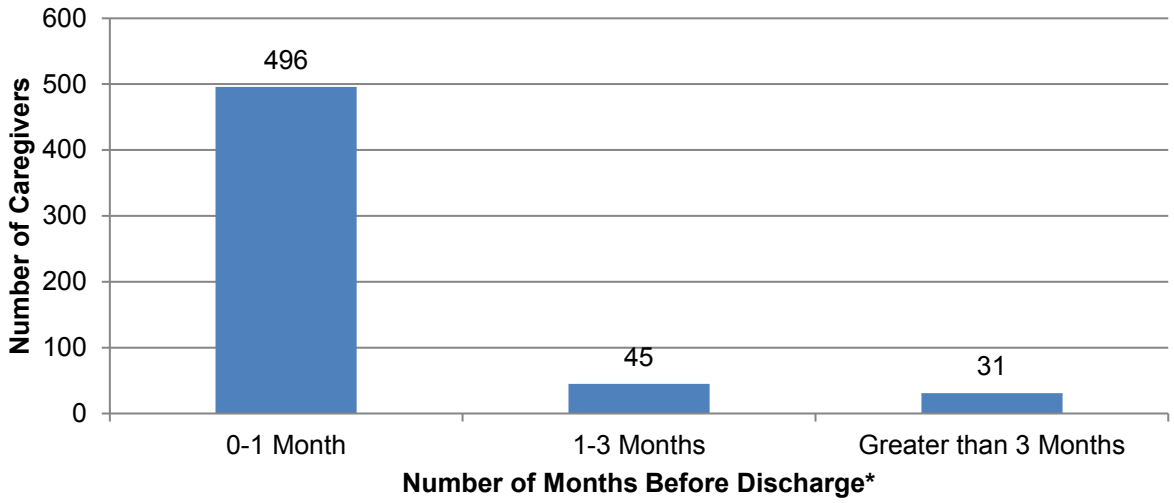

***Figure 1**. Timeliness of Veteran and Caregiver Discharge Following a Death from May 2011 through April 2018*
**0-1 Month = 0-30 days, 1-3 Months = 31-90 days, Greater than 3 Months = 91 or more days.*
(Source: OIG analysis of a comparison of CAT and heath records to veteran and caregiver SSA death records)

[26] The audit team used $208,200 for reporting purposes. This amount is rounded from the $208,152 which is part of the overall $241,782 of improper costs associated with veteran and caregiver deaths. The remaining $33,630 relates to improper payments that occurred due to OCC not cancelling payments timely.

[27] 38 Code of Federal Regulations, § 71.45, *Revocation* (c), May 4, 2011, Caregiver Support Program, *Caregiver Application Tracker User Manual Caregiver Application Tracker,* April 28, 2014, and VHA Directive 1152, Section 7.c(3).

CSCs should take prompt action to discharge deceased veterans and caregivers following a death to ensure OCC cancels caregiver stipends and prevents improper payments. In total, the audit team identified three cases in which CSCs took more than a year to discharge program participants following a death. Examples of two of these cases are detailed below. In the most egregious case, a CSC took almost three years after the veteran's death to discharge the veteran and his caregiver, and then cancel the stipend. This case is discussed in the second finding of this report.

Example 1

A veteran at the VA Loma Linda Healthcare System in California was approved for the program in September 2013. The veteran died in late 2017, but CSCs did not discharge the veteran and caregiver until June 2018. This veteran was never monitored by a CSC or clinician, as required. VHA improperly paid the caregiver about $19,000 in stipends. OCC initiated recoupment actions for these overpayments and recovered nearly all funds.

Example 2

A veteran at the Fayetteville VA Medical Center in North Carolina was approved for the program in September 2012. The veteran died in late 2013, but the caregiver remained enrolled in the program until December 2014. CSCs and clinicians only monitored the veteran twice. VHA improperly paid the caregiver about $12,200 in stipends. As with the example above, as of January 2019, OCC had initiated recoupment actions for these overpayments, but no funds had yet been recovered.

Discharges of Veterans Following an Institutionalization

According to VHA guidance, veterans institutionalized either because of incarceration or hospitalization can remain in the Family Caregiver Program if they are expected to return home within six months. CSCs should discharge an institutionalized veteran and their caregiver when it is determined that the veteran will not return home within six months of the date of admission. VA guidance and VHA Directive 1152 require OCC to extend caregiver stipends for 90 days after the veteran's discharge from the program.[28] It should be noted that program guidance does not address what should happen when caregivers are incarcerated or hospitalized.

CSCs took timely action to discharge about 92 percent (33 of 36) of veterans who were or would be incarcerated for six or more months and their caregivers. In addition, CSCs appropriately did

[28] Draft VHA guidebooks, VHA Directive 1152, Section 7.c(3)., and Caregiver Support Program Standard Operating Procedure, *Revocation for Institutionalization and Incarceration*, July 2018.

not discharge 44 veterans and their caregivers, who were incarcerated for six months or less. However, CSCs delayed the discharges of three veterans (3 of 36), and their caregivers, who were incarcerated for more than six months. In total, the audit team questioned at least $36,400 that VHA paid to these incarcerated veterans' caregivers.[29] The following examples describe two of these cases.

Example 3

A veteran with posttraumatic stress disorder enrolled in the program at the Fayetteville VA Medical Center was incarcerated at a state prison for about 13 months during January 2014 through March 2015. The CSC, however, did not discharge the veteran and caregiver from the program. CSCs reported to the audit team that facility personnel lost track of the veteran during this period due to employee turnover, but a CSC identified the incarceration in October 2015 when scheduling a clinical reassessment. The veteran remained in the program after a nurse at the medical center determined the veteran was still clinically eligible later that month. The team questioned about $31,000 that VHA paid in caregiver stipends.

Example 4

A veteran experiencing posttraumatic stress who was enrolled in the program at the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan, was incarcerated in a county jail in September 2017. In January 2018, the caregiver informed the CSC that the veteran would remain in jail until the trial, which was scheduled for April 2018—seven months from when the veteran was first incarcerated. At this point, the CSC should have discharged the veteran and the caregiver because the length of stay was expected to last longer than six months. However, the CSC did not discharge the veteran from the program until March 2018, and extended caregiver stipends for an additional three months. The CSC reported to the audit team that, in consultation with the program lead, the decision was made to keep the veteran enrolled until the trial date due to the uncertainty of the case. Understanding that the decision-making process can be complicated, the CSC decided to wait, rather than risk prematurely discharging the veteran. The team questioned about $2,600 that VHA paid in caregiver stipends.

[29] The total amount of questioned payments VHA made when veterans were incarcerated is rounded. Appendix C details how the audit team calculated monetary benefits.

CSCs took timely action to discharge about 78 percent (14 of 18) of veterans who had been hospitalized for more than six months, and their caregivers. CSCs appropriately did not discharge 12 veterans who were hospitalized for less than six months. However, CSCs delayed discharges for four of 18 veterans who were hospitalized for more than six months, and their caregivers. As a result, the audit team questioned at least $78,000 that VHA paid to these veterans' caregivers.[30] The following examples describe two of these cases.

Example 5

A veteran with a traumatic brain injury and a spinal injury enrolled in the program at the VA San Diego Healthcare System in California was hospitalized from January 2015 to August 2015 for 209 days. In June 2015, the CSC documented a decision by a clinical eligibility team to discharge the veteran based on a hospitalization exceeding six months. However, the CSC reported that due to her own lack of oversight, the decision was never implemented. The veteran was released from the hospital two months later. The CSC confirmed that the veteran and caregiver should have been discharged in June 2015. The audit team questioned about $38,200 that VHA paid in caregiver stipends.

Example 6

A veteran with a spinal injury was enrolled in the program at the Hampton VA Medical Center in Virginia in December 2016. In January 2017, the veteran's caregiver informed a nurse that the veteran was placed in the medical center's spinal cord unit, with no expectation of returning home, and requested discharge from the program. The nurse should have informed the CSC, who then should have discharged the veteran and caregiver because the length of stay was expected to exceed six months. However, because the CSC was not notified of the veteran's long-term hospitalization by the caregiver until April 2017, the discharge was delayed by about three months. The audit team questioned about $8,300 that VHA paid in caregiver stipends.

Timeliness of Canceled Stipends

OCC almost always took timely action to cancel caregiver stipends once CSCs discharged veterans and their caregivers from the Family Caregiver Program following a veteran's death, or veteran institutionalization (incarceration or hospitalization).[31] The audit team identified two

[30] Appendix C details how the audit team calculated monetary benefits.

[31] The audit team compared discharge dates in CAT to payment dates in the Financial Management System to identify payments made to caregivers beyond the allowable extension periods.

instances in which a CSC discharged a veteran promptly, but OCC personnel did not cancel their caregivers' stipends, resulting in about $33,600 in improper payments.[32] OCC personnel attributed these errors to the manual process used to cancel these payments. As of January 2019, OCC initiated recoupment actions for one of these overpayments totaling about $27,600 and recovered about $4,000. As of January 2019, for the other payments totaling about $6,000, OCC was determining if these should be considered overpayments and what, if any, recoupment actions were necessary.

Controls to Reduce the Risk of Future Errors

Despite relatively low error rates, VHA should improve program oversight because significant funds are being put at risk as the number of caregivers is expected to triple over five years. The opportunities to identify deaths, incarcerations, or hospitalizations that should trigger discharges from the program are influenced by whether these events are identified through an automated data system, detection by program officials, or reports from veterans or caregivers. Table 4 details the system or personnel responsible for identification and the added controls the audit team determined could improve discharge timeliness. None of the suggested controls were in place at the time of this audit.

Table 4. Controls to Improve Discharge Timeliness

Responsible system or personnel	Time to identify a status change	Control
CAT system	Close to immediate	Integration with other VA data sources
Office of Community Care	Monthly	Data matching prior to caregiver stipend payment
Veteran or caregiver	Immediately	Accountability to report status change

Source: OIG analysis of death, incarceration, and hospitalization notification process

While VHA did implement a program control that required CSCs to monitor veterans and caregivers quarterly,[33] this control was not effective because it was not consistently implemented. The OIG reported in its prior *Audit of the Program of Comprehensive Assistance for Family Caregivers,* that CSCs did not identify changes in veteran and caregiver conditions because required monitoring did not occur in a timely manner or consistently.[34] The OIG recommended VHA establish policies and implement procedures to improve the timeliness and

[32] The total amount of improper caregiver stipends that VHA paid because of OCC errors is rounded. Appendix C details how the team calculated monetary benefits.

[33] 38 Code of Federal Regulations § 71.40, *Caregiver Benefits*, (b)(2) and VHA Directive 1152, Sections 5.j(1) and c.(5).

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

consistency of monitoring, document changes in veterans' health status, and adjust veterans' tier levels of care or discharge veterans and their caregivers, as appropriate. Improvements in the quarterly monitoring of veterans and their caregivers in conjunction with the implementation of the controls detailed in Table 4 could position CSCs to more quickly identify deaths, incarcerations, and hospitalizations. This, in turn, would reduce VHA's risk of making improper and questionable caregiver payments.

Data System Lacks Matching Capabilities with Other VA Data Sources

At the time of this audit, CSCs could not systematically identify deceased, imprisoned, or hospitalized veterans or caregivers. CAT does not have the capability to match program participants' personal information against Veterans Benefits Administration (VBA) death and incarceration data and VHA's hospitalization data. According to the National CSP director, there was an urgency to develop CAT when the program was first launched in 2011, which resulted in VHA focusing on system requirements over data-matching capabilities. During the audit, VHA reported it was developing the Caregiver Tool to replace CAT. The audit team received a demonstration of the system and observed some of its functionality, which included the capability to integrate with VA's death data to identify deceased veterans and some caregivers. The Caregiver Tool was not expected to have the capability to systematically identify incarcerated or hospitalized veterans or caregivers.

In April 2019, VA Office of Information and Technology officials reported that they were in the process of developing a new information technology system—the Caregiver Record Management Application—to support VA MISSION Act of 2018 requirements and had halted efforts to further develop the Caregiver Tool. The MISSION Act requires VA to implement an information technology system that can comprehensively monitor program workload before accepting applications from all-era veterans. The MISSION Act also requires that the information technology system can integrate with other VHA information systems. According to VA Office of Information and Technology officials, this new system should be in testing by early FY 2020. VA Office of Information and Technology officials reported that the Caregiver Record Management Application is expected to be able to process, track, and manage caregiver applications, as well as automate some stipend payment processes.

Without knowing what the ultimate capabilities of VA's new Caregiver Record Management Application will be, CSCs continue to rely on information collected during quarterly monitoring sessions with veterans and caregivers to identify changes in their status. VHA should leverage available data sources to match against Family Caregiver Program data to manage its risk of making improper or questionable payments. VHA should initiate periodic data matching of enrolled veterans and their caregivers against VA death, incarceration, and hospitalization data.

Death Notifications Need Strengthening

VHA did not immediately establish a requirement for CSCs to make veterans and caregivers aware that they were responsible for promptly notifying the CSC in the event of a veteran or caregiver death. While VHA issued a document in 2017 outlining roles and responsibilities, it does not address what veterans and caregivers should do if there is a death.[35] Because CSCs only monitor program participants quarterly, the OIG recommends that VHA include prompt death notification responsibilities and procedures for participants in that document.

Program Policy on Institutionalized Veterans Needs Clarification

As of December 2018, the Family Caregiver Program has operated for over seven years. During this time, the National CSP Office issued a range of guidance, including draft guidebooks, a directive, and a standard operating procedure. However, VHA's guidance did not consistently include incarcerations in its definition for institutionalizations or establish time frames for how long a veteran can remain institutionalized before CSCs should discharge them and their caregivers (see Table 5).

[35] *VA Caregiver Support, Roles, Responsibilities and Requirements for The Program of Comprehensive Assistance for Family Caregivers*, July 2017.

Table 5. Institutionalization Discharge Procedures

Guidance	Date	Incarceration included in definition	Incarceration not included in definition	Time frame included	Time frame not included
38 Code of Federal Regulations, Part 71, *Interim Final Rule*	May 2011		X		X
Draft *Caregiver Support Program Guidebook*	April 2012		X		X
Draft *Caregiver Support Program Guidebook*	June 2013		X	X	
38 Code of Federal Regulations, Part 71, *Final Rule*	January 2015		X		X
Draft *Caregiver Support Program Guidebook*	April 2015	X		X	
Directive 1152, *Caregiver Support Program*	June 2017		X		X
Caregiver Support Program Standard Operating Procedure, *Revocation for Institutionalization and Incarceration*	July 2018	X		X	

Source: OIG analysis of the Caregiver Support Program guidance from May 2011 through July 2018

It was not until July 2018—soon after the start of this audit—that the National CSP Office released a standard operating procedure that included incarcerations and the requirement that the veteran must be institutionalized for six months before they and their caregivers are discharged from the program. However, when a veteran is incarcerated, that veteran is no longer receiving care at home nor is the caregiver capable of providing caregiving services to the veteran. This contradicts the primary veteran eligibility requirement for the Family Caregiver Program detailed in Table 1 of this report, which states that the individual agrees to receive care at home after VA designates a family caregiver. Furthermore, program guidance is lacking on actions CSCs should take when caregivers are incarcerated or hospitalized.

While caregiver stipends are not disability benefits like those paid to veterans with service-connected injuries, the National CSP Office should consider that federal law requires VBA to reduce disability benefits for incarcerated veterans. Specifically, VBA must reduce disability benefits for incarcerated veterans who are in a federal, state, or local correctional facility for more than 60 days. Effective the 61st day of incarceration, VBA must reduce benefits for veterans convicted of a felony and discontinue pension benefits for veterans convicted of a

felony or misdemeanor.[36] Once the veteran is released from the facility, these benefits can be restored.

National CSP Office personnel admitted they did not fully consider how incarcerations could affect program eligibility for veterans and their caregivers. During reviews of 80 incarcerated veterans' files, the audit team identified indications that at least 25 percent (20) of the veterans were charged with felonies while enrolled. The team understands the National CSP director's concerns about immediately discharging incarcerated veterans and their caregivers and the burden it would place on them to reapply to the program. However, VHA is at risk of paying caregiver stipends for as much as nine months (six months to remain enrolled in the program and three additional months of caregiver stipends following discharge) while the veteran is incarcerated.

Reapplication Processes Are Lacking for Veterans and Caregivers Discharged Because of Institutionalizations

According to the National CSP director, formerly enrolled veterans must reapply following a hospitalization or incarceration regardless of whether their health condition, need for care, or caregiver have remained unchanged. In addition, CSCs do not have the mechanisms to suspend veterans' and their caregivers' program enrollment during an incarceration or hospitalization so that services can be restarted quickly. The OIG contends that the lack of an expedited reapplication process or a suspension option can put unnecessary hardships on both CSCs and clinicians, and place veterans and their caregivers at risk of not receiving timely access to program services and benefits.

Applying for the Family Caregiver Program can take a long time. The OIG reported in the *Audit of the Program of Comprehensive Assistance for Family Caregivers* that an estimated 65 percent of the 1,822 veterans approved for the Family Caregiver Program from January through September 2017 did not have their applications approved within 45 days, as required by VHA Directive 1152. In more than half of these cases, CSCs took from three to six months to approve these applications.

With program expansion, CSCs and clinicians will encounter an influx of new applications, potentially causing institutionalized veterans and caregivers, who had previous approvals, to wait unnecessarily. Consider the experiences of two veterans whose cases the audit team reviewed.

Example 7

A veteran was incarcerated in August 2016. The veteran and caregiver were discharged from the program two months later when it was determined that the

[36] United States Code: Title 38, Part III, Chapter 15, § 1505.(a) and Part IV, Chapter 53, § 5313.(a)1.

veteran would remain in prison for more than six months. After being released from prison, the veteran reapplied to the Family Caregiver Program in August 2018 and was readmitted 84 days later in October 2018.

Example 8

A veteran was hospitalized in December 2017 and was discharged from the program because the veteran was not going to return home. After leaving the facility in March 2018, the veteran decided to reapply for the program in July 2018. In October 2018, the veteran was determined to be clinically ineligible and not accepted back into the program—a wait of about three months for a decision after reapplying. At the time of this report, the veteran had not taken any action to appeal the denial.

VHA has an opportunity to implement a working group to further assess institutionalizations within the program and how to handle discharge and reapplication processes for these veterans. The working group could include program experts, legal stakeholders, and representatives from VBA. VHA should consider time frames and whether there should be differentiating requirements for institutionalized veterans who are incarcerated versus hospitalized. It also should contemplate implementing expedited reapplication processes (or a suspension process) following institutionalization and revise its program guidance accordingly.

Recommendations 1–3

Recommendation 1. The Under Secretary for Health establishes processes to conduct matching, at least quarterly, of the records of enrolled veterans and their caregivers against the Department of Veterans Affairs' death, incarceration, and hospitalization data to help ensure timely program discharges and to reduce the risk of improper and questionable payments.[37]

Recommendation 2. The Under Secretary for Health takes steps to outline in the program's roles and responsibilities document what the veteran and caregiver responsibilities are for promptly notifying caregiver support coordinators of deaths.

Recommendation 3. The Under Secretary for Health institutes a program working group to clarify inconsistencies and gaps in program guidance. Specifically, the working group should determine if incarcerated or hospitalized veterans or caregivers should adhere to different discharge requirements. The working group should also consider the time frames for discharges, a process for veterans and caregivers to reapply to or be suspended from the program following a

[37] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary.

discharge due to incarceration or hospitalization, and should initiate updating program guidance accordingly.

Management Comments

The Under Secretary for Health concurred in principle with Recommendation 1 and concurred with Recommendations 2 and 3 of the report and included limited technical comments. To address Recommendation 1, the VHA's Office of Community Care established a monthly data match with current approved veterans and primary family caregivers participating in the program against the Social Security Death Index. In addition, the Under Secretary for Health agreed to assess the feasibility for obtaining and integrating available data on death, incarceration, and hospitalization of veterans and their caregivers into the Caregiver Record Management Application upon completion of the actions related to this recommendation. Specifically, the Caregiver Support Program initiated discussions with various groups, including the Office of Information and Technology, to understand how VHA can leverage existing agreements and databases to integrate them into procedures for matches on incarceration and hospitalization data. To address Recommendation 2, VHA will update the roles and responsibilities document accordingly, update the Standard Operative Procedure governing the utilization of this document, train CSCs on the changes made, and establish a plan for communicating changes to current and incoming program participants. To address Recommendation 3, VHA will establish a workgroup to conduct a review, identify gaps, and make recommendations for needed changes. As applicable, VHA's Caregiver Support Program will update program guidance and establish and implement a communications plan to inform CSCs.

OIG Response

The Under Secretary for Health's planned corrective actions are responsive to Recommendations 2 and 3 and should address almost all the issues identified in the report. While the Under Secretary agreed in principle with Recommendation 1 and the planned actions are initially responsive, the OIG maintains additional steps are necessary. VHA's plan included data matching to identify deceased veterans and their caregivers, but it did not fully address recommended data matching to identify incarcerated or hospitalized program participants. According to VHA, it will report on the feasibility for obtaining available data on death, incarceration, and hospitalization of veterans and their caregivers and integrating this data into the Caregiver Record Management Application. The Caregiver Record Management Application is expected to be deployed in June 2020. These planned actions meet the intent of the recommendation. The OIG will monitor VHA's progress on its proposed actions until the intent of the recommendations is addressed. The OIG will then close these recommendations. The OIG incorporated VHA's limited technical comments, as appropriate, in the report. Appendix D provides the full text of the Under Secretary for Health's comments.

Finding 2: A VA Medical Facility Coordinator's Delays in Discharging a Deceased Veteran's Caregiver Led to Overpayments

The audit team substantiated the allegation that VHA overpaid about $71,000 to the caregiver of a deceased veteran at the medical facility referenced in the OIG Hotline allegation.[38] The veteran died in late March 2015, yet the facility's CSC did not discharge the veteran and the caregiver from the Family Caregiver Program until almost three years later in February 2018. Program guidance specified that CSCs had the primary responsibility for updating status changes in CAT as they occur, including the death of a veteran. CSCs also were supposed to discharge the veteran and caregiver from the program immediately following a death. Stipends to the veteran's caregiver should have continued for no more than 90 days after the veteran's death.[39]

What the OIG Did

The audit team conducted a site visit to the VA medical facility referenced in the OIG Hotline allegation in June 2018. The team interviewed the chief of staff, program officials, and CSCs who were responsible for the Family Caregiver Program at the facility. The team reviewed the CAT records for the veteran and his caregiver, as well as the veteran's electronic health record. Appendix B provides additional details on the audit scope and methodology.

Notifications to CSC about Veteran's Death Failed to Prompt Discharge

The medical facility's CSC accepted responsibility for not discharging the veteran and caregiver until nearly three years following the veteran's death. The audit team determined the following—dates in red represent key dates in the chronology of events:

February 26, 2015: The caregiver program's registered nurse who conducted the veteran's initial in-home eligibility assessment noted in the veteran's electronic health record that the veteran's cancer was progressing. The CSC indicated her awareness of the veteran's declining health when she confirmed receipt of the nurse's initial in-home assessment in the veteran's record.

[38] The total amount of improper caregiver payments that VHA paid to the caregiver of the deceased veteran is rounded. The audit team only included these improper payments in the first finding of this report. Appendix C details how the team calculated monetary benefits.

[39] VHA, draft *Caregiver Support Program Guidebook*, updated on June 11, 2013.

March 16, 2015: The veteran was approved for the program at the highest level of care, which included a monthly caregiver stipend of about $2,500 paid to the veteran's wife.

Late March 2015: The veteran died.

April 30, 2015: The CSC reported that a social worker at the medical facility had notified her via the veteran's electronic health record that the veteran died. The CSC then reported attempting to contact the caregiver to verify the veteran's death. The CSC explained that she never heard back from the caregiver and mistakenly left the veteran enrolled in the program.

The audit team confirmed that on the same day, an Operation Enduring Freedom/Operation Iraqi Freedom program registered nurse also noted in the veteran's electronic health record that the veteran died from cancer. However, the CSC did not confirm the information nor update the veteran's status in CAT.

September 27, 2016: The caregiver program registered nurse emailed the CSC that the veteran died after trying to schedule the annual in-home visit with the veteran and his caregiver.

October 14, 2016: The same caregiver program registered nurse added a note to CAT reporting the veteran died. While the nurse had CAT system access to discharge this veteran and caregiver from the program, the nurse reported that it was not part of the nurse's job responsibilities to discharge participants from the program, as the CSC maintained that role with the program.

February 26, 2018: OCC program personnel identified that the veteran was still receiving stipends, but had died, and contacted the medical facility program personnel for confirmation. The CSC discharged the veteran and caregiver from the program.

April 20, 2018: OCC program personnel initiated a recoupment of approximately $71,000 in improper payments made to the caregiver.

June 11-12, 2018: The audit team contacted VHA personnel about conducting a visit to the medical facility. The following day, the social work chief reported that the CSC confirmed that the deceased veteran's caregiver received stipends after the veteran's death.

July 18, 2018: OCC started the process of recouping about $71,000 in improper payments made to the caregiver. The caregiver returned about $29,000 in one payment. As of January 2019, the caregiver has not made any additional payments.

October 19, 2018: The caregiver reported that repaying the remaining $43,000 posed a financial hardship and requested VA waive the requirement to do so.

March 11, 2019: OCC denied the caregiver's waiver request.

Multiple Oversight Failures Allowed the Deceased Veteran to Remain Enrolled, with Resulting Caregiver Overpayments

The CSC reported that her workload, which included managing the VA medical facility's Family Caregiver Program of approximately 240 enrolled veterans, caused her to miss discharging the veteran when she was notified of the death. This is consistent with the OIG's prior *Audit of the Program of Comprehensive Assistance for Family Caregivers* in which program CSCs reported concerns that workload and understaffing affected their ability to perform monitoring tasks. The OIG has recommended that VHA assess the extent to which staffing levels at medical facilities are adequate to implement the Family Caregiver Program, as intended.

The facility's social work chief and social work program coordinator, who were responsible for supervising CSCs, did not hold the CSC accountable for program monitoring and timely discharges. On June 28, 2018, the social work chief issued standard operating procedures intended to ensure future compliance with Family Caregiver Program regulations and guidelines. This procedure requires CSCs to provide updates on the status of the program to medical facility and program leaders. Compliance with these processes on reporting the status of veterans and caregivers enrolled in the program should position these leaders to proactively identify when a discharge is required, and caregiver stipends should be stopped.

Conclusion

In 94 percent of the cases the OIG examined, VHA acted in a timely manner to discharge veterans and caregivers from the Family Caregiver Program related to a death or disqualifying incarceration or long-term hospitalization. However, the OIG audit revealed weaknesses in program controls resulting in VHA making improper and questionable payments for caregiver stipends that should have been canceled and directed only to eligible veterans and their caregivers. These weaknesses, if not corrected, will continue to expose VHA to unnecessary financial risk as the program expands significantly through FY 2023.

During the audit, the team also substantiated the allegation that the CSC at the VA medical facility referenced in the allegation did not discharge a veteran from the Family Caregiver

Program for nearly three years following notification of the veteran's death, resulting in the veteran's caregiver being improperly paid about $71,000. The CSC's inaction was not detected because the facility lacked adequate reporting to facility and program leaders to ensure program requirements were being met. In response, the facility has already taken some steps that should address these deficiencies. No additional recommendations were made related to the allegation involving the CSC and related oversight because the facility has begun taking remedial action, and because the recommendations made to address the deficiencies in the first finding of the report will also be applicable here.

Appendix A: Background

Family Caregiver Program

CSCs at 140 VA medical facilities operate the Family Caregiver Program.[40] In FY 2018, VHA reported spending about $385 million on caregiver stipends—a dramatic increase of about 388 percent from the approximately $79 million on caregiver stipends that VHA spent during the first full year of program operations in FY 2012. Most of this spending increase was because of the growth in the number of veterans enrolled in the Family Caregiver Program.

According to VHA, enrollment in the program peaked at about 22,800 in FY 2016 and has since declined to about 19,800, as of September 2018. The number of enrolled veterans discharged from the Family Caregiver Program peaked in FY 2016 at 4,300 for that year. In FY 2017, discharges decreased to about 3,900 when the VA Secretary temporarily suspended Family Caregiver Program discharges from April through July 2017. Discharges increased again to about 4,300 in FY 2018. Since FY 2011, VHA enrolled an average of about 4,800 veterans in the Family Caregiver Program and discharged an average of about 2,400 veterans with their caregivers annually. The following figure identifies the number of veterans participating in the Family Caregiver Program from May 2011 through September 2018, as well as the number of program approvals and discharges.

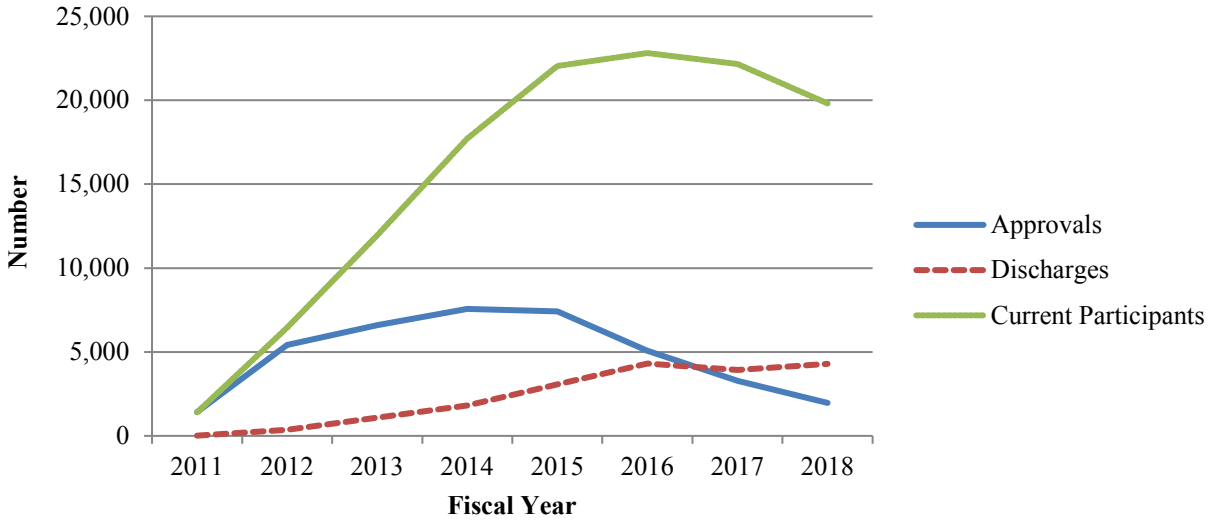

Figure A.1. *Family Caregiver Program Enrollment and Discharge Trends from May 2011 through September 2018*
(Source: VHA reported CAT data)

[40] Some VA medical facilities have multiple campuses or associated facilities. Some CSCs are assigned to one location or have responsibility for multiple locations associated with one facility.

Veterans Hospitalized While Enrolled in the Family Caregiver Program

Veterans enrolled in the Family Caregiver Program experienced about 12,600 hospitalizations from May 1, 2011, through April 30, 2018, in VA and private medical facilities. Most veteran hospitalizations (5,775) were between one and 29 days. A summary of the types and lengths of hospital stays are provided in Table A.1.

Table A.1. Number of Veterans and Associated Hospitalization Stays (in days)

Type of Stay	1–29	30–59	60–89	90–119	120–149	150–179	180–359	360 and greater
VA inpatient	3,032	300	88	34	19	9	21	4
Fee inpatient	1,285	49	13	1	2	1	4	6
VA extended	317	357	129	67	32	16	36	3
Fee extended	1,141	26	9	3	1	0	2	5
Totals	**5,775**	**732**	**239**	**105**	**54**	**26**	**63**	**18**

Source: OIG analysis of VHA hospitalization data for veterans enrolled in the Family Caregiver Program
Note: This table represents the hospitalization stays in VA and private medical facilities for about 4,700 veterans. Some of these veterans had multiple hospitalizations during the time frame.

Prior OIG Reports

The OIG issued two reports since August 2014 that examined the Family Caregiver Program.

- In the *Audit of the Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed* (Report No. 17-04003-222, August 16, 2018), the OIG determined VHA discharged veterans without consistently monitoring their health conditions. Clinicians and CSCs either did not adequately document the extent to which veterans' health conditions changed in their electronic health record or failed to routinely monitor these veterans and their caregivers prior to the clinical reassessment that led to their discharge from the program. In total, the OIG questioned about $41.6 million that VHA paid to caregivers of veterans discharged from the program from January through September 2017 because the required monitoring to determine ongoing eligibility for the program was not performed. The OIG made recommendations related to eligibility determinations, monitoring, staffing, and governance. These recommendations were open as of December 2018.
- In the *Healthcare Inspection: Deficiencies in the Caregiver Support Program Ralph H. Johnson VA Medical Center Charleston, South Carolina* (Report No. 14-00991-255, August 21, 2014), the OIG substantiated the allegation that an interdisciplinary team had not appropriately assessed many veterans during the application process. Facility leadership did not designate an interdisciplinary CSP team or develop a comprehensive assessment process until February 2014. As of January 27, 2014, more than 200 patients were awaiting CSP eligibility screening,

with 164 of them waiting longer than the 45-day requirement. The OIG found that the facility had placed a hold on all new applications while it addressed the care and monitoring of active participants in the program. The OIG also found that CSP staff did not conduct 90-day and annual follow-up visits. The OIG found that staffing was not sufficient to address the volume of work. Therefore, caregivers received stipends without confirmation that the patients and caregivers met program requirements. The OIG made recommendations to the facility director including eligibility assessments, timeliness of application processing, and in-home monitoring reviews. The OIG considers these recommendations closed.

The OIG also issued two reports since June 2016 concerning benefits paid after a veteran's death or incarceration.

- In the *Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths* (Report No. 16-00252-137, March 27, 2017), the OIG determined VHA made improper payments to non-VA care providers for deceased veterans, but did not find a systemic issue. The OIG recommended VHA recover the improper payments identified and ensure VA medical facilities update non-VA care authorizations for deceased veterans, as required by VHA policy. The OIG considers these recommendations closed.
- In the *Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans* (Report No. 13-02255-276, June 28, 2016), the OIG found that VA Regional Office and Pension Management Center staff did not take consistent and timely action to adjust compensation and pension benefits to veterans incarcerated in federal, state, and local penal institutions. This occurred because staff did not place a high priority on incarceration adjustments. The OIG made recommendations including VBA recovering improper payments and increasing the priority of VBA's incarceration adjustment workload. This included making timely and appropriate adjustments to the compensation and benefit payments. The OIG considers these recommendations closed.

Appendix B: Scope and Methodology

Scope

The OIG conducted its audit work from June 2018 through March 2019. The audit team reviewed a total of 682 veterans and caregivers. This included all 652 veterans and caregivers who matched death and incarceration records and were enrolled in the Family Caregiver Program at some point from May 1, 2011, to April 30, 2018; and a judgmental sample of 30 veterans enrolled at some point during this time who matched hospitalization records. Table B.1 details the number of veterans and caregivers who the team reviewed for each life event.

Table B.1. Veterans and Caregivers Reviewed During the Audit

Life event	Number of program participants
Death	572
Incarceration	80
Hospitalization	30
Total	**682**

Source: OIG analysis of a comparison of CAT and veteran computerized health care records to the SSA death file, state and federal incarceration data, and VHA hospitalization data from May 2011 through April 2018

The audit team also reviewed an allegation made to the OIG Hotline in March 2018 involving the discharge of a deceased veteran and his caregiver by a CSC at the VA medical facility referenced in the allegation.

Methodology

To gain an understanding of when and how veterans and their caregivers should be discharged from the Family Caregiver Program, the audit team examined relevant criteria, including Public Law 111-163, *Caregivers and Veterans Omnibus Health Services Act of 2010*; Title 38 United States Code § 1720G, *Assistance and support services for caregivers*; draft *Caregiver Support Program Guidebooks*; and VHA Directive 1152, *Caregiver Support Program*. The team also reviewed the *Caregiver Application Tracker User Manual* to understand how CSCs process program discharges in the system.

To answer the audit objective, the team compared the enrollment status of veterans and caregivers in CAT to the following data:

- SSA Death Master File
- SSA State and Federal Bureau of Prisons Files
- VHA's Medical Statistical Analysis System Inpatient and Outpatient Data Sets

The SSA Death Master File includes death notices for veterans and caregivers enrolled in the U.S. Social Security program since 1936. Federal Bureau of Prisons files capture incarceration data on veterans and caregivers confined in a federal institution. SSA data on individuals incarcerated in state or local prisons includes veterans, as well as caregivers who are collecting VBA benefits, such as disability benefits or a pension. No incarcerated caregivers were identified through these data sources.

VHA hospitalization data captures data on veterans and caregivers receiving care at a VA medical facility or care paid for by VA at a non-VA facility. This data set does not capture information on caregivers and veterans who may have received inpatient care at a private medical facility that was paid for through private health care insurance, Medicare, or Medicaid. No hospitalized caregivers were identified through these data sources.

To measure how timely VHA canceled caregiver stipends after a discharge from the program, the audit team used data from VA's Financial Management System. The team reviewed documentation to identify actions, if any, OCC took to recover payments made to caregivers in error.

The audit team interviewed the National CSP director to learn about the process for documenting and discharging veterans and caregivers from the Family Caregiver Program due to death, incarceration, or hospitalization. In addition, the team contacted CSCs and program officials from 19 VA medical facilities regarding the application of discharge procedures following a death, incarceration, or hospitalization. The team interviewed program officials from VHA's OCC to determine the process for canceling stipends following a discharge from the program. The team also observed a demonstration of the Caregiver Tool information system to learn about its capabilities to process information related to the program, particularly veteran or caregiver death, incarceration, or hospitalization information.

Site Visit

The audit team conducted a site visit to the VA medical facility referenced in the OIG Hotline allegation in June 2018. During this visit, the team toured the facility's social work office and conducted six interviews of personnel involved with overseeing and implementing the CSP at the medical facility. These interviews included the chief of staff, social work chief, social work program coordinator, and CSCs. The team also reviewed local program processes and procedures to identify processes for discharging deceased veterans from the Family Caregiver Program.

Data Collection Instrument

The audit team developed and used an electronic data collection instrument to review the records of incarcerated and hospitalized veterans in CAT and in VA's Computerized Patient Record System. This instrument captured the elements required by Public Law 111-163, Title 38 United

States Code § 1720G, *Caregiver Support Program Guidebooks* (draft), and VHA Directive 1152. These criteria were applicable for the veterans who were enrolled in the program at some point from May 2011 through April 2018. The team took steps in the development of the data collection instrument to ensure the information that was collected was accurate and incorporated second-level reviews of veterans' files and electronic health records.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur within the context of the audit objective. Alert to these risks, the team exercised due diligence in taking the following actions:

- Conducted steps to review program operations for potential fraud
- Coordinated with the OIG's Office of Investigations concerning potential fraud indicators
- Considered potential fraud indicators when reviewing veteran participant files

The team did not identify any instances of potential fraud during this audit.

Data Reliability

The audit team assessed the reliability of CAT data on veterans and caregivers who died or were incarcerated or hospitalized while enrolled in the Family Caregiver Program or were discharged because of these status changes. In addition, the team assessed the reliability of the data on these program participants captured in the SSA death file, state and federal incarceration, and VHA hospitalization data sets. The team conducted these assessments to determine if the data was sufficient to identify current participants who died or were incarcerated or hospitalized by matching against veteran and caregiver program files and electronic health records. The team also assessed the reliability of VA's Financial Management System data to determine if this data was sufficient for calculating stipends made to caregivers of enrolled veterans during the scope of the audit.

The audit team tested CAT data by verifying that individual files were maintained in the system. The team compared data in these files with information contained in veterans' electronic health records in the Computerized Patient Record System. Furthermore, the team compared veteran and caregiver information from CAT and veterans' electronic health records with the SSA death file, state and federal incarceration information, and VHA hospitalization data. In addition, the team obtained additional months of state and federal incarceration data to assure these data sets were complete for the scope of the audit. The team also included data reliability questions in the data collection tool used to review files as an additional verification of the data obtained from CAT. The team verified the accuracy of information collected from participant files with CSCs at selected medical facilities. The team compared stipend data from CAT with information from

VA's Financial Management System and OCC recoupment documentation, which included its Family Caregiver Program recoupment spreadsheet, request for recoupment and discharge forms, and payee check and billing information. The team also discussed the reliability of stipend data with responsible program personnel. Based on these reliability assessments, the team concluded the data was appropriate and sufficient for purposes of the audit.

Estimates for Hospitalized and Incarcerated Veterans

The audit team did not review enough hospitalized veterans to be representative of the entire population. In addition, the team could not determine the length of incarceration for some incarcerated veterans because their records did not always include confinement start or release dates. As a result, the team could not estimate potential errors and overpayments for these veterans in future years.

Estimating Potential Errors and Overpayments for Deceased Veterans and Caregivers

The audit team, in consultation with an OIG statistician, developed an estimate of potential errors and overpayments that may occur in the future if VHA does not improve its program controls related to regularly monitoring the status of veterans and caregivers to identify a death. The overpayment amount for FY 2019 through FY 2023 was calculated using estimates for the number of future program participants, death percentage for veterans and caregivers, the overpayment error rate, and the average overpayment amount. To determine the expected growth of the program, the team used the Congressional Budget Office's estimates for the number of additional program participants and implementation cost included in *H.R. 5674 VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act) (the Congressional Budget Office report).[41] Section 161 of H.R. 5674 expands the program in two stages to eligible veterans of any era.

Future Program Participants

Estimating the number of program participants for FY 2019 through FY 2023 was a multi-step process. First, the audit team estimated the veteran discharge rate using the rounded average of FY 2016 through FY 2018—the last three FYs of program operation. This average discharge rate was 19 percent. There is no data on future program discharges. While the team cannot be certain that the number of veterans discharged from the program will not change in the future, using the rounded average of the last three FYs is a reasonable estimate of future program growth. The

[41] Congressional Budget Office Cost Estimate, H.R. 5674 *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (MISSION Act), May 14, 2018.

team then calculated the number of discharges for FY 2019 through FY 2023 as the product of the overall discharge rate multiplied by the number of veteran participants in the previous FY.[42]

Second, the audit team estimated program approvals for FY 2019 through FY 2023. Given the lack of data on future program approval rates for post-September 2001 veterans, the team used the rounded average approval rate for FY 2016 through FY 2018. There is no data on the number of post-September 2001 veterans who will be approved for the program in the future. While the team cannot be certain that the approval rate for these veterans will not change in the future, using the rounded average approval rate of the last three FYs is a reasonable estimate of future program growth. This rounded average approval rate was 3,400 veterans per year.

Third, the audit team used estimates from a Congressional Budget Office report detailing how the VA MISSION Act of 2018 would expand the Family Caregiver Program in two stages from FY 2019 through FY 2023. Stage I is expected to include a one-time influx of 16,900 veterans in FY 2019 and continue increasing to 35,500 total veterans by the end of FY 2023. No information is given in the report for how the increase will occur in FY 2020 through FY 2023, so the team assumed that the increase would be constant each year. In other words, after the initial expected influx of an estimated 16,900 veterans in FY 2019, the team estimated that 4,650 veterans will be added to the program each year through FY 2023. The Congressional Budget Office estimated that there will be an additional one-time increase of 24,700 veterans in Stage II of the program's expansion, which is expected to occur in FY 2021.

Then to calculate the total number of veteran participants for a future FY, the audit team added the total veteran participants of the previous FY to the number of new veterans approved to participate in the program, and new program participants associated with Stage I and/or Stage II of the program's expansion. They then subtracted the number of veterans who were discharged from the program that year. The formula below illustrates the team's calculation:

[FY 2020 total veteran participants (37,669)] + [FY 2021 veteran approvals (3,400)] – [FY 2021 veteran discharges (7,100)] + [FY 2021 estimated Stage I increase (4,650)] + [FY 2021 estimated Stage II increase (24,700)] = Total veteran participants in FY 2021 (63,319)

There will be one caregiver per veteran, so the total will be twice the number of veteran participants. Table B.2 shows how the audit team calculated the future number of veteran participants.

[42] The number of discharges is rounded to the nearest hundred to avoid implying precision in the value.

Table B.2. Total Number of Veteran Participants FY 2011 through FY 2023

Fiscal year	Number of veteran approvals	Number of veteran discharges	Estimated Stage I increase	Estimated Stage II increase	Total veteran participants
2011	1,419	15	-	-	1,404
2012	5,408	367	-	-	6,445
2013	6,602	1,090	-	-	11,957
2014	7,565	1,811	-	-	17,711
2015	7,416	3,078	-	-	22,049
2016	5,073	4,310	-	-	22,812
2017	3,276	3,934	-	-	22,154
2018	1,955	4,290	-	-	19,819
2019	3,400	3,700	16,900	-	36,419
2020	3,400	6,800	4,650	-	37,669
2021	3,400	7,100	4,650	24,700	63,319
2022	3,400	11,900	4,650	-	59,469
2023	3,400	11,100	4,650	-	56,419

Source: OIG analysis of VHA reported CAT data for veteran approvals and discharges from FY 2011 through FY 2018 and Congressional Budget Office estimated increases for FY 2019 though FY 2023
Note: The number of veteran approvals and discharges are rounded to avoid implying precision.

Percentage of Deaths Among Veterans and Caregivers

The audit team calculated the percentages of deaths separately for veterans and caregivers. These percentages are based solely on veteran and caregiver deaths that occurred during FY 2012 through FY 2017, and not on any other source of longevity or actuarial tables. The team calculated an overall percentage of deaths among veterans and caregivers as the average of each group's death percentage in each FY. The team used this percentage as a reasonable estimate for future veteran and caregiver deaths given available data.

The audit team used the percentage of deaths among veterans and caregivers to estimate how many program participants will die in FY 2019 through FY 2023. This is an underestimate as Stage I and II will include pre-September 11, 2001, veterans—who are generally older than the current program participants who are all post-September 11, 2001, veterans. It is likely that pre-September 11, 2001, veterans will experience death at a higher percentage because they are older. Table B.3 details the team's death percentages calculations.

Table B.3. Veteran and Caregiver Death Percentages FY 2012 Through FY 2017

Fiscal year	Number of participants	Number of veteran deaths	Percent of veteran deaths	Number of caregiver deaths	Percent of caregiver deaths
2012	6,445	26	0.40%	-	-
2013	11,957	66	0.55%	2	0.02%
2014	17,711	68	0.38%	2	0.01%
2015	22,049	103	0.47%	5	0.02%
2016	22,812	121	0.53%	5	0.02%
2017	22,154	99	0.45%	11	0.05%

Source: OIG analysis of VHA reported CAT data on veteran participants and OIG identified deaths from FY 2012 through FY 2017
Note: The audit team used the number of participants by FY to calculate the death percentages for veterans and caregivers separately. The team only considered FY 2012 through FY 2017 in its calculations because the program started in May 2011 and the audit scope ended in April 2018.

Table B.4 shows the veteran and caregiver calculated mean and corresponding 90 percent confidence intervals on the mean. For the death percentage calculation, the audit team assumed that there were an equal number of veteran and caregiver participants for each FY.

Table B.4. Descriptive Statistics for Veteran and Caregiver Death Percentage – 90 Percent Confidence Level

Participant type	Death percentage mean	Lower limit	Upper limit
Veteran	0.46%	0.41%	0.52%
Caregiver	0.02%	0.01%	0.03%

Source: OIG statistical analysis of identified veteran and caregiver deaths from FY 2012 through FY 2017

Overpayment Error Rate

The overpayment error rate was calculated as the sum of the number of veterans or caregivers who received an overpayment (N=30) divided by the sum of the number of veteran or caregiver deaths (N=508). The overpayment error rate for FY 2012 through FY 2017 was 5.9 percent. Table B.5 details the number of program participants who died and the number who received an overpayment each year for FY 2012 through FY 2017.

Table B.5. Rate of Deceased Veterans or Caregivers who Were Overpaid in Error during FY 2012 through FY 2017

Fiscal year	Number of veteran or caregiver deaths	Number of veterans or caregivers who received an overpayment	Overpayment error rate
2012	26	-	0.0%
2013	68	3	4.4%
2014	70	5	7.1%
2015	108	10	9.3%
2016	126	6	4.8%
2017	110	6	5.5%

Source: OIG analysis of identified veteran and caregiver deaths and the number of dead program participants who received an overpayment from FY 2012 through FY 2017
Note: FY 2012 is the first full fiscal year the Family Caregiver Program operated. Because the audit team's scope went through April 2018—representing a portion of FY 2018—the team did not include this portion of this fiscal year in its overpayment rate calculation.

The overall overpayment error rate and associated 90 percent confidence interval are shown in Table B.6.

Table B.6. Descriptive Statistics for Overpayment Error Rate – 90 Percent Confidence Level

Overpayment error rate mean	Lower limit	Upper limit
5.90%	4.28%	7.93%

Source: OIG statistical analysis of overpayment error rates from FY 2012 through FY 2017

Average Overpayment

The audit team calculated the average overpayment amount per veteran or caregiver with overpayments as the sum of the overpayment amounts ($241,782.01) divided by the total number of participants with overpayments (N=30). The overall average overpayment amount was $8,059.40. Table B.7 details all the overpayments that occurred because of a veteran or caregiver death in FY 2012 through FY 2017. Because of the 100 percent review, no descriptive statistics were calculated.

Table B.7. Average Overpayment Amount Related to Caregiver or Veteran Deaths from FY 2012 through FY 2017

Fiscal year	Overpayment amount	Number of caregivers or veterans who received an overpayment	Average overpayment amount
2012	-	-	-
2013	$7,461	3	$2,487
2014	$31,454	5	$6,291
2015	$142,732	10	$14,273
2016	$29,647	6	$4,941
2017	$30,487	6	$5,081
Total	**$241,782**	**30**	**-**
Overall Average Overpayment Amount			**$8,059**

Source: OIG analysis of identified overpayments associated with veteran and caregiver deaths from FY 2012 through FY 2017
Note: While deaths occurred in FY 2012, the audit team did not identify any overpayments related to these deaths. Overall average overpayment amount does not total due to rounding.

Estimated Overpayment Amounts

The audit team used the results of the calculations for number of program participants, death rate, overpayment error rate, and average overpayment amount per participant to estimate overpayment amounts for FY 2019 through FY 2023. For the calculations that used death percentages or overpayment errors rates, the team used the mean values for those estimates. The limits on the confidence intervals could be used to show ranges for future overpayment estimates.

The audit team assumed the number of veteran and caregiver participants would be equal, so the estimate of veteran participants was also used as the estimate of caregiver participants. The team multiplied the number of participants by the appropriate FY death rate to calculate the number of deaths in each group. The team added the deaths for each group to find the total number of deaths, and then multiplied the results by the overpayment error rate to calculate the number of participants who received overpayments. Finally, the team multiplied the number of participants with overpayments by the average overpayment per participant amount to find the total estimated overpayment amount for each FY. Table B.8 details the team's estimates related to veteran and caregiver deaths and resulting stipend overpayments expected for FY 2019 through FY 2023.

Table B.8. Overpayment Estimates for FY 2019 through FY 2023

Fiscal year	Number of veteran participants	Number of veteran deaths	Number of caregiver deaths	Total deaths	Number of participants with overpayment errors*	Overpayment amount
2019	36,419	169	7	176	10	$83,779
2020	37,669	175	8	182	11	$86,654
2021	63,319	293	13	306	18	$145,660
2022	59,469	276	12	287	17	$136,804
2023	56,419	261	11	273	16	$129,787
Total	**-**	**-**	**-**	**-**	**72**	**$582,685**

Source: OIG estimates of veteran and caregiver overpayments from FY 2019 through FY 2023
Note: Total overpayment amount does not total due to rounding.
[*] *Values of the number of veteran and caregiver deaths and the number of participants with overpayment errors were rounded for this table, however, the audit team performed calculations with unrounded numbers.*

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The OIG believes that the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1 and 2	Value of improper payments made to caregivers when VHA did not take timely action to discharge deceased veterans and caregivers from the Program of Comprehensive Assistance for Family Caregivers or promptly stop caregiver stipend payments from May 2011 through April 2018.		$241,782[43]
1 and 2	Value of future improper payments from FY 2019 through FY 2023, when VHA does not timely discharge deceased veterans and caregivers from the Program of Comprehensive Assistance for Family Caregivers.		$582,685[44]
3	Value of questioned payments to caregivers when veterans were incarcerated and hospitalized and not removed timely from the Program of Comprehensive Assistance for Family Caregivers from May 2011 through April 2018.		$114,334[45]
	Total		**$938,801**

[43] The audit team calculated $241,782 by summing the excess caregiver payments due to untimely discharges ($137,230) with the improper payments the VA medical facility referenced in the OIG Hotline allegation made to the caregiver of the deceased veteran which is discussed in the second finding of this report ($70,922) and errors OCC made canceling payments ($33,630) from May 2011 through April 2018.

[44] In coordination with an OIG statistician, the audit team estimated future improper payments from FY 2019 through FY 2023 to be $582,685 when VHA does not timely discharge veterans and caregivers following a death. See Appendix B for a discussion regarding how the team calculated the number of program participants, death rate, overpayment error rate, and average overpayment amount per participant to estimate the future overpayment amounts for FY 2019 through FY 2023, if VA does not take corrective action.

[45] The audit team calculated $114,334 by summing $36,356 made in excess caregiver payments when veterans were incarcerated with the $77,978 in questioned caregiver payments when veterans sampled were hospitalized from May 2011 through April 2018.

Appendix D: Management Comments

Department of Veterans Affairs Memorandum

Date: June 14, 2019

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

Subj: OIG Draft Report, Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement (VIEWS 00226825)

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

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report on Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement. I concur in principle with recommendation 1 and concur with recommendations 2 and 3. I provided the attached action plan to address all 3 recommendations.

2. I am pleased that OIG determined we took timely and appropriate action to discharge 94 percent of those participating in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) when the discharge was due to the death of the Veteran or caregiver, or Veteran's incarceration or hospitalization. Since the program's inception 8 years ago, there have been only seven incidences in the categories of incarceration and hospitalization overpayments amounting to $114,400.

3. The Caregiver Support Program is pursuing regulatory changes to stabilize and improve the PCAFC which will address several of OIG recommendations. Any proposed changes to PCAFC will be subject to public comment and the rule making process.

4. An information technology solution is currently in development to replace the current system and support our ability to expand PCAFC as required by the MISSION Act. We anticipate this replacement solution will integrate with other data systems to even more effectively oversee and monitor PCAFC participants.

5. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison at VHA10EGGOALACTION@va.gov.

(Original signed by)

Richard A. Stone, M.D.

Attachment

Attachments

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement

Date of Draft Report: March 27, 2019

Recommendations/ Actions	Status	Completion Date

Recommendation 1: The Executive in Charge for the Veterans Health Administration establishes processes to conduct matching, at least quarterly, of the records of enrolled veterans and their caregivers against the Department of Veterans Affairs' death, incarceration, and hospitalization data to help ensure timely program discharges and to reduce the risk of improper and questionable payments.

VHA Comments: Concur in principle

VHA concurs in principle with the importance of conducting data matching of Veterans and Primary Family Caregivers participating in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) to ensure timely program discharges. In March 2019, using February 2019 data, the Veterans Health Administration's (VHA) Office of Community Care (OCC) established a monthly data match with current approved Veterans and Primary Family Caregivers participating in the PCAFC against the Social Security Death Index. This will enable the OCC to mitigate untimely Veteran death entries resulting in improper payments within PCAFC. By conducting this manual data match on a monthly basis, VHA believes that Veterans and Primary Family Caregivers approved for PCAFC are able to be identified in a timely manner. When such identification occurs, OCC immediately contacts the Caregiver Support Coordinator (CSC) of any Veteran or Primary Family Caregiver reported in the data match for follow up.

Currently, PCAFC information technology systems are not capable of capturing data on deaths, incarceration or hospitalization of Veterans and Primary Family Caregivers enrolled in the program. Importantly, most caregivers are private citizens who obtain their health care from community providers. VHA does not have independent access to city, county, state, or Federal prison databases where information on incarcerations might be found. In a good faith effort, the Caregiver Support Program has initiated

discussions with the Office of Information Technology (OIT), US Digital Services and the Veterans Benefit Administration (VBA) to understand how VHA can leverage existing agreements and integrate into existing procedures currently utilized by VBA for Veteran matches on incarceration data. VHA will continue this collaboration effort and work with OIT and US Digital Services at VA on determining the feasibility of a technical solution. Should we uncover a feasible solution, VHA will pursue it. The Caregiver Support Program has also been in discussions with OIT, US Digital Services, the Veteran Experience Office, and Identity and Access Management to understand how best to leverage any existing data bases to integrate notifications of Veteran hospitalizations within and known to the VA to the Caregiver Record Management Application (CARMA) expected to deploy June 2020.

At completion of actions on this recommendation, VHA will provide documentation of a report on feasibility for obtaining available data and integration of data on death, incarceration and hospitalization of Veterans and Primary Family Caregivers into CARMA.

Status:	Target Completion Date:
In progress	60 days following publication of OIG's final report

Recommendation 2: The Executive in Charge for the Veterans Health Administration takes steps to outline in the program's roles and responsibilities and document what the veteran and caregiver responsibilities are for promptly notifying caregiver support coordinators of deaths.

VHA Comments: Concur

VHA's Caregiver Support Program utilizes a document titled, Roles, Responsibilities and Requirements, to inform and educate Veterans and Family Caregivers of expectations governing participation in the PCAFC. A requirement for Family Caregivers to promptly inform the Veteran/Servicemember's primary care team and the CSC of changes in the Veteran's condition is among the expectations cited, as is the expectation for Veterans to provide notification if the Primary Family Caregiver is no longer providing personal care services. While it was our understanding that death is encompassed in these expectations, we agree that this was not explicitly stated and should be further clarified. We also agree additional guidance should be offered as to how to make these notifications. VHA will update the Roles, Rules and Responsibilities document accordingly, update the Standard Operative Procedure governing the utilization of this document, train CSCs on the changes made, and establish a plan for communicating changes to current and incoming PCAFC participants.

Status:	Target Completion Date:
In process	October 2019

Recommendation 3: The Executive in Charge for the Veterans Health Administration institutes a program working group to clarify inconsistencies and gaps in program guidance. Specifically, the working group should determine if incarcerated or hospitalized veterans or caregivers should adhere to different discharge requirements. The working group should also consider the time frames for discharges, and a process for veterans and caregivers to reapply to or be suspended from the program following a discharge due to incarceration or hospitalization and should initiate updating program guidance accordingly.

VHA Comments: Concur

VHA agrees that review and analysis of current guidance governing the PCAFC is needed to ensure consistency and will establish a workgroup to conduct this review, identify gaps, and make recommendations for needed changes. As applicable, VHA's Caregiver Support Program will update program guidance and establish and implement communications plan to inform CSCs.

In January 2018, VA published a notice in the Federal Register seeking public comment on specific questions to improve the current PCAFC; this included consideration of modifications to timeframes for discharges. VHA is currently considering regulatory changes needed to improve the current PCAFC as well as regulations to govern the expanded PCAFC as directed by VA MISSION Act. As policy decisions are finalized, VHA will seek recommendations from a workgroup or panel of individuals on the feasibility and advisability of establishing an expedited reapplication process for Veterans and caregivers who have been discharged from PCAFC due to incarceration or hospitalization.

Status:	Target Completion Date:
In process	March 2020

VETERANS HEALTH ADMINISTRATION (VHA)
Technical Comments

OIG Draft Report: Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement

1. Suggested change throughout the draft report:
   OIG specifying "Primary Family Caregiver" versus the generic term "caregiver" when referring to those who are receiving stipend payments.

   Justification:
   Veterans participating in the Program of Comprehensive Assistance for Family Caregivers may designate one Primary Family Caregiver and up to two Secondary Family Caregivers. Only the designated Primary Family Caregivers is eligible to receive a monthly stipend. Lack of this specificity may lead to confusion among the general public when this report is published.

2. Suggested change (page 3, paragraph 2): The term proposal be replaced with "policy consideration."

   Justification: In November 2018 there was no formal proposal to change the stipend payment methodology, rather this was among the policy decisions under consideration. There is no formal proposal at this time, as such change is subject to the rule making process.

3. Suggested change (page 4, table 2): Add reasons for discharge not listed: "Veteran or caregiver request" and "Veteran no longer clinically eligible."

   Justification: Accuracy of *all* the reasons a Veterans and caregiver may be discharged.

4. Suggested change (page 4, table 2): Add "to encompass 'for cause' and 'noncompliance'" to box with "Veteran or caregiver no longer meet primary program eligibility requirements."

   Justification: Accuracy and better understanding of the nature of discharges.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of1973, as amended.

OIG Contact and Staff Acknowledgments

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