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VETERANS HEALTH ADMINISTRATION

Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services

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Executive Summary

VA's *FY 2018–2024 Strategic Plan* includes the objective of eliminating veteran homelessness. The Health Care for Homeless Veterans (HCHV) Program, a component of the Veterans Health Administration's (VHA) Homeless Program Office, provides outreach, case management, and transitional housing to veterans experiencing homelessness who want to obtain permanent housing. VA medical facility staff work with Contracted Residential Services (CRS) program contractors to provide temporary housing and services to veterans experiencing homelessness while helping them transition to stable housing.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA effectively monitored veterans and administered CRS contracts to ensure veterans received needed services, contractors met the terms and conditions of their contracts, and VHA used funds appropriately.

What the Audit Found

The audit team found improved case management documentation and monitoring are needed to ensure veterans receive appropriate transitional housing services. Case management is an ongoing, cooperative process between facilities and veterans to evaluate veteran needs, plan treatment, assess if the treatment is working, and advocate for changes to treatment plans. Documenting this process helps provide veterans with the best care possible and establishes a record for continuity of care if veterans require multiple stays in medical facilities. In order to properly monitor and oversee veterans' progress at the contractor residences, CRS staff should have regular communication with the veterans and contractor staff.

VHA could not confirm that all veterans participating in CRS programs received the assistance and services they needed to transition to permanent housing due to incomplete case management documentation and inconsistent monitoring. The audit team reviewed the electronic health records of 168 sampled veterans who were enrolled in CRS programs at six medical facilities between May 1, 2018, and April 30, 2019 (the review period). CRS staff at these six medical facilities did not consistently document the case management services provided to over half of the sampled veterans. Eighty-six of the 168 reviewed veterans (51 percent) lacked required case management documentation. VHA policy does not explicitly define the amount of contact CRS staff should have with veterans or contractor residence staff to monitor veterans while they are in the program, other than the requirement that CRS staff maintain, at a minimum, monthly progress notes to track veterans' progress. Thus, interviews with CRS staff at the reviewed medical facilities and contractor residence staff disclosed that the monitoring of veterans varied greatly between the medical facility CRS programs. For example, CRS program staff at one medical facility acknowledged they did not consistently conduct monthly follow-up visits or calls to monitor veterans until after a Homeless Program Office audit identified monitoring

issues, while CRS staff at other facilities reported they regularly communicated with veterans and contract staff at residences even if they did not always document their contacts or meetings in the veterans' electronic health records.

Based on these results, the team projected about 3,400 of the 6,800 veterans (50 percent) in the 24 largest CRS programs—those with expenditures exceeding $1 million—had case management documentation deficiencies during the audit's review period.[1] CRS staff provided various reasons for the case management documentation and monitoring problems, including staffing and resource constraints that made it difficult for them to monitor veterans across multiple residences and different policy interpretations as to what needed to be documented in the veterans' electronic health records. Moreover, VHA's Homeless Program Office did not establish controls at the regional network or medical facility levels to identify noncompliance with program requirements.

The audit team also reviewed a sample of 14 CRS contracts during the review period and found stronger contract monitoring and administration are needed to safeguard veteran and taxpayer interests. CRS staff—who also served as contracting officer's representatives (CORs) and were members of the medical facility inspection teams—did not always ensure contractors met CRS program and contract requirements. The audit team reviewed the *Health Care for Homeless Veterans Program Handbook* (the handbook) and CRS contracts, which require contractors to maintain, at a minimum, sanitary housing, case management documentation for program participants, and a medication control system.[2] However, four of the 14 CRS contracts reviewed had performance deficiencies in these three areas, and one of these contracts resulted in improper payments of up to $592,000.[3] These deficiencies could affect the health and safety of veterans living in transitional settings. Furthermore, VA lacks assurance veterans received the services required by the contracts.

In addition, CORs did not always properly monitor payments and comply with contract and regulatory requirements to prevent improper payments. These issues in 13 of 14 reviewed CRS contracts at the six reviewed medical facilities led to an estimated $7 million in improper

[1] The statistically projected error rate does not match the error rate from the sample due to the statistical weighting of the sample. For more information on the audit scope and methodology and statistical sampling methodology, refer to appendixes A and B.

[2] VHA Handbook 1162.09, *Health Care for Homeless Veterans Program*, May 2, 2014.

[3] OMB Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. The appendix states, "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. When an agency's review is unable to discern whether a payment was proper due to insufficient or lack of documentation, the payment must also be considered improper even if there is no monetary loss." Appendix C of this report presents monetary impact.

payments, of which about $6 million was considered technically improper.[4] Contracting officers did not always provide letters of delegation to CORs giving them the authority to approve payments and monitor contractors; CORs at one medical facility did not make sure contractors provided three daily meals or the means to purchase and prepare meals as required by the contracts; and one COR did not obtain supporting documentation, as required by the contract, prior to approving invoices.

The contract monitoring and administration deficiencies led to an estimated $7.6 million in improper payments. Based on this amount, the team estimated that VHA made about $35.3 million in improper payments on 107 of the 119 contracts (90 percent) during the 12-month period ending April 30, 2019, due to contract monitoring and administration deficiencies.[5] Of the total improper payment amount, about $21.6 million was considered technically improper.[6]

Contract monitoring problems occurred because contracting officers did not always hold and document quarterly meetings with CORs to evaluate contractor performance as required.[7] Further, contracting officers did not always include quality assurance surveillance plans in contracts as required, or make certain that CORs used surveillance plans when they were included in the contracts.[8] In addition, CORs may have reduced the effectiveness of their own monitoring when they provided contractors advance notice of annual inspections and quarterly evaluations. For example, one COR, who provided advance notice of the inspections, did not find any case management documentation deficiencies in the one annual inspection and three

[4] The *FY 2019 OMB Paymentaccuracy.gov Data Call Instructions* define a technically improper payment as a payment made to the right recipient for the correct amount, but the payment process failed to follow an applicable statute or regulation. This definition of a technically improper payment is also included in OMB Circular A-123, app. C, "Requirements for Payment Integrity Improvement," issued on March 5, 2021. Although the time frame of this audit preceded the March 2021 circular, the payments at issue are technically improper under both the *FY 2019 OMB Paymentaccuracy.gov Data Call Instructions* and the circular.

[5] The audit statistically selected contracts from large CRS programs that had expenditures in excess of $1 million during the review period. This resulted in a universe of 24 programs with a total of 119 contracts and about $51 million in expenditures.

[6] The remaining $13.7 million is an estimate of the total estimated improper payments and represents the possible monetary losses associated with CRS contract monitoring and administration deficiencies during the 12-month review period. However, the audit team did not consider these estimated improper payments recoverable based on its review. A lack of documentation prevented the team from calculating the specific amounts due from each contractor, or the calculated amounts were so small that a recovery was not warranted.

[7] The handbook states that as part of ongoing monitoring activities, the COR and contracting officer will have documented quarterly meetings. VHA Procurement Manual, part 801.603-70, "Contracting Officer Representative SOP [Standard Operating Procedure]," March 11, 2019. The manual states contracting officers must meet with CORs on at least a quarterly basis for all healthcare services contracts, document that the meeting took place, and note the items reviewed and discussed.

[8] FAR 37.601(b)(2) requires performance-based contracts for services to include "measurable performance standards … and the method of assessing contractor performance against performance standards." FAR 46.401(a) states quality assurance surveillance plans should be prepared in conjunction with the preparation of the statement of work and specify all work requiring surveillance and the method of surveillance.

quarterly evaluations conducted prior to the audit. However, the audit team's unannounced visit to this contractor's residence disclosed the contractor was missing significant amounts of case management documentation for all 28 veterans the audit team reviewed.

The contracting officers the audit team interviewed attributed contract administration problems, such as the failure to delegate authority to the CORs and to hold and document quarterly meetings with CORs to evaluate contractor performance, to contracting office turnover, limited staff, overwhelming workloads, and the contracting officers' inexperience with healthcare contracts. Further, Network Contracting Offices' peer reviews, which were intended to detect these types of administration problems in the contracts, did not detect the CRS contract files lacked required copies of COR delegation letters and documentation of quarterly evaluation meetings with the CORs. Finally, CORs sometimes overpaid contractors and authorized payments for days after the veterans had already exited the program or exceeded the number of contractually allowed absences.[9] These overpayments occurred because the CORs did not always obtain supporting documentation for contract invoices, and because contracts varied on the extent VA could pay for absences, potentially leading to confusion. The audit team also noted that the lack of guidance on the payment of allowable veteran absences in CRS national policy appeared to contribute to the variations in the contracts' provisions and the CORs' authorization of improper payments.

What the OIG Recommended

The OIG made three recommendations to the acting under secretary for health to improve documentation of case management services, contractor monitoring, and contract administration. The OIG recommended (1) establishing monitoring controls to ensure CRS staff comply with handbook requirements, (2) updating VHA Handbook 1162.09 to incorporate unannounced site visits for annual inspections and quarterly evaluations, and (3) including guidance in the handbook on paying for veteran absences, as well as making certain that these requirements are reflected in contracts and surveillance plans.

The OIG also made two recommendations to the VHA executive director for procurement to improve oversight of contractor residences and administration of contracts to ensure veterans receive quality care and to prevent improper payments. The OIG recommended (1) establishing controls to verify contracting officers meet at least quarterly with CORs to evaluate contractor performance and document the meetings, and (2) including quality assurance surveillance plans for contracts and ensuring their use, as well as making certain nominated individuals are properly delegated CORs.

[9] Some contracts may allow contractors to bill VA for a limited number of days when veterans are absent.

Management Comments

The acting under secretary for health concurred with recommendations 1, 4, and 5 and concurred in principle with recommendations 2 and 3, which were directed to the VHA executive director for procurement. The OIG will monitor VHA's progress and follow up on the implementation of the action plans for recommendations 1, 4, and 5 until all proposed actions are completed.

The OIG did not find the action plans for recommendations 2 and 3 responsive because they only state the VHA executive director for procurement will "remind" contracting officers of the Federal Acquisition Regulation (FAR) and VA policy responsibilities discussed in the recommendations. These action plans do not meet the intent of the OIG's recommendations, which was to have the VHA procurement office establish additional controls to help prevent the recurrence of the problems in CRS contract oversight and administration identified by the audit. The OIG will close recommendations 2 and 3 when VHA establishes additional controls to help prevent the recurrence of these problems.

Lastly, the acting under secretary for health also made general comments stating that VHA does not agree with the OIG's classification of the payments in this report as improper payments. VHA contends the OIG has inappropriately applied VHA's procurement manual as a regulatory document in its discussion of improper payments and that it has inappropriately applied the term improper payments, misinterpreted the FAR, and confused improper payments with problems in contractor performance in various sections of the report. VHA's detailed comments are presented in appendix D.

In response, the OIG acknowledges VA's position that the VHA Procurement Manual may not be policy. However, internal correspondence between VA contracting leaders and VHA contracting staff states the manual guidance is derived from, and is consistent with, federal regulations and that contracting staff should follow it to the greatest extent practicable unless deviations have been granted. The OIG did not find that any deviations had been granted. The OIG also contends that it has not inappropriately applied the term improper payments because Office of Management and Budget (OMB) Circular A-123, appendix C, states a payment can be technically improper even if it was made to the right recipient for the right amount, but the payment process failed to follow applicable statute and regulation. FAR 32.905 states payments to the contractor will be based on a proper invoice and satisfactory contractor performance, and as the OIG has discussed at length in the report, VHA did not have properly delegated CORs in place to evaluate satisfactory contractor performance. Because FAR 32.905 is an applicable regulation related to the payment process, the OIG determined the subject payments meet the definition of a technically improper payment even though payments were made to the right recipients for the right amount.

During an earlier discussion of the improper payments with VHA, the OIG indicated the contracting officers had not ensured the proper acceptance of the CRS services as required by

FAR 46.502 and that this made the related payments improper.[10] VHA states in its comments that the OIG misinterpreted FAR 46.501 and that contracting officers are only responsible for obtaining evidence of acceptance. However, VHA's comments do not acknowledge the OIG's main point. Under FAR 46.501, "Acceptance constitutes acknowledgement that the supplies or services conform with applicable contract quality and quantity requirements … " and acceptance could not be performed in accordance with the FAR because an authorized official, either the contracting officer or a properly delegated COR, had not evaluated the contractors' performance. While the team and VHA discussed this issue prior to issuing the draft report, it is not mentioned in the finding or key to the OIG's position on technically improper payments.

Finally, for those contracts where the OIG identified contractor performance issues, the OIG disagrees with VHA's position that performance issues cannot result in improper payments because OMB Circular A-123 makes it clear an improper payment exists if the government pays for a service that is not received.

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[10] FAR 46.502 states that acceptance of supplies and services is the responsibility of the contracting officer.

Contents

Abbreviations

COR	contracting officer's representative
CRS	Contracted Residential Services
FAR	Federal Acquisition Regulation
FY	fiscal year
HCHV	Health Care for Homeless Veterans
OIG	Office of Inspector General
OMB	Office of Management and Budget
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted this audit to determine whether the Veterans Health Administration (VHA) had adequate oversight of and monitored Contracted Residential Services (CRS) at VA medical facilities to ensure they operated effectively and helped veterans experiencing homelessness transition to permanent housing. Specifically, the audit assessed whether VA medical facilities

- properly monitored and documented the progress of veterans who participated in the programs, and
- effectively administered CRS contracts to ensure contractors met the terms and conditions of their contracts and used funds appropriately.

One of VA's *FY 2018–2024 Strategic Plan* objectives is to make sure at-risk and underserved veterans receive what they need to end veteran homelessness. The CRS program allows VA medical facilities to work with contractors to provide temporary housing and case management services to veterans as they prepare for and transition to permanent housing. The program provides residential services to vulnerable veterans in challenging situations, such as veterans experiencing homelessness along with serious mental health and substance use disorders, including veterans who had difficulties with traditional treatment programs. In fiscal year (FY) 2018, VA paid 320 contractors about $103.2 million to provide residential services to roughly 16,300 veterans.[11] The program poses challenges and risks for VA because, as the Government Accountability Office noted in its 2019 High-Risk List, VA has historically had significant problems providing adequate oversight of its contractors.[12]

Health Care for Homeless Veterans Program and Goals

The Health Care for Homeless Veterans (HCHV) program office, a component of VHA's Homeless Program Office, provides outreach, case management, and contracted residential services to veterans who are experiencing homelessness. Under the CRS program, VA medical facilities contract with partners in the community to provide eligible veterans time-limited transitional housing services (usually up to 90 days, with the option to extend based on clinical need) and other needed care, treatment, and rehabilitative services. The program's goal is to help veterans transition to permanent housing upon discharge from the program.

[11] This number represents the total number of veterans who received services and exited the CRS program in FY 2018. FY 2018, ending in September 2018, was the most recent full year of data available at the time of this audit.

[12] Government Accountability Office, *Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-393T, March 6, 2019.

The US Code authorizes VA to provide outreach, treatment, and therapeutic transitional housing assistance to veterans experiencing homelessness.[13] The Code of Federal Regulations further specifies that transitional housing needs to provide a safe environment that promotes community interaction; treatment plans must be developed in coordination with VA and the contractor; residents must be assisted in maintaining appropriate hygiene; and meals, when served, must be adequate and nutritious.[14]

HCHV Program Office Oversight and Governance Structure

The HCHV program office provides guidance on laws, regulations, and program policies. It also compiles performance data for the CRS program as part of the Homeless Services Scorecard provided to Veterans Integrated Service Networks and medical facilities.[15] The Homeless Services Scorecard includes two performance metrics with target goals for the CRS program: "exits to permanent housing" and "negative exits."[16] Veterans who are discharged from the program upon obtaining permanent housing, such as an apartment, are counted as exits to permanent housing. Veterans who have been asked to leave the program due to a violation of rules (excluding exits due to threatened or actual violence to self or others), who have failed to comply with requirements, or who leave the program on their own initiative without consulting staff are counted as negative exits. Table 1 shows how VHA's CRS program performed nationally compared to the targets in FYs 2018 and 2019.

Table 1. CRS Performance Targets and Performance

Performance measure	FY 2018		FY 2019	
	Target	National performance	Target	National performance
Exits to permanent housing	50%	51%	53%	55%
Negative exits	20%	22%	23%	19%

Source: Data obtained from VHA Support Service Center's Homeless Services Scorecard.
Note: According to the national director of clinical operations for the Homeless Program Office, medical facilities within Veterans Integrated Service Networks are required to score at or above the target percentage for the performance measure of exits to permanent housing, and at or below the target percentage for negative exits. Some medical facilities consistently failed to meet one or both performance measures.

[13] 38 U.S.C. § 2031.

[14] 38 C.F.R. pt. 63.

[15] VHA is organized into 18 regional networks called Veterans Integrated Service Networks. Each regional network is led by a director who is responsible for the coordination and oversight of administrative and clinical activities at medical facilities within the specified geographic area.

[16] According to the national director of clinical operations for the Homeless Program Office, the program office sets the goals and defines the criteria for the two metrics, including what is considered a negative exit.

The *Health Care for Homeless Veterans Program* handbook (the handbook) discusses the roles and responsibilities of key staff at the national program office, regional Veterans Integrated Service Network offices, and local medical facilities. Table 2 summarizes the key roles and responsibilities for the CRS program.

Table 2. CRS Program Roles and Responsibilities

Roles	Responsibilities
HCHV program office director and staff	• Provides technical assistance and corrective actions to the field and evaluates the facilities' performance relative to the CRS performance targets
Network homeless coordinator	• Ensures the medical facilities perform initial and annual inspections and the medical facility directors review the reports • Provides guidance to medical facility program staff through routine communications, including regular site visits • Assists CRS program staff in developing corrective actions when the program's performance targets are not met
Medical facility director	• Oversees contracted residential services to ensure the programs provide quality services in compliance with laws and regulations and in accordance with contracts • Makes certain that an HCHV coordinator is designated • Ensures the completion of initial and annual inspections to confirm the residences meet the standards prescribed in VHA's *Health Care for Homeless Veterans Program Handbook* and approves the CRS residences' participation before veterans can be placed at the residences[17] • Ensures initial and annual inspections of contractors' facilities and processes are completed in a timely manner

[17] The handbook requires an interdisciplinary team of VA staff to evaluate each contractor's facilities, safety procedures, food and nutrition, clinical documentation, and medication policies and procedures.

Roles	Responsibilities
Medical facility HCHV coordinator	• Develops local processes for verifying veteran eligibility, screenings, entries, and exits • Ensures coordination of services with other programs serving individuals experiencing homelessness • Performs the role of COR or nominates a qualified COR, whose functions include monitoring the contractor's performance according to the quality assurance surveillance plan and reviewing billing accuracy[18]

Source: VHA Handbook 1162.09, Health Care for Homeless Veterans Program.

VA's Patient Care Responsibilities

VA medical facility CRS staff are social workers who provide supportive clinical case management services to veterans to help them obtain permanent housing. In order to promote the best outcomes for these veterans, the handbook requires CRS staff to evaluate veterans when they first enter the program and to monitor their progress throughout their stay in the contracted transitional homes. CRS staff and contractors should communicate regularly and work collaboratively to address each veteran's treatment and care needs to help veterans reach the goal of permanent housing.

Contractors document their case management notes in their own administrative files and do not provide copies to VA unless requested.[19] For this reason, VHA policy requires CRS staff to document all treatment plans and progress toward those plans in the veterans' VA health records to ensure continuity of care.[20] Many veterans served by the program have chronic mental health and substance use disorders, and documenting veteran progress in treatment is imperative to keeping VA clinicians fully aware of obstacles to attaining permanent housing. The handbook requires medical facility CRS staff to have complete case management process documentation available in each veteran's VA health record.

[18] FAR 37.601(b)(2) requires performance-based contracts for services to include "measurable performance standards … and the method of assessing contractor performance against performance standards." FAR 46.401(a) states quality assurance surveillance plans should be prepared in conjunction with the preparation of the statement of work and specify all work requiring surveillance and the method of surveillance.

[19] HCHV agreements require contractors to provide case management and administrative services while veterans live in the transitional homes to help them move to permanent housing.

[20] The handbook requires HCHV case management services to ensure continuity of care, either as an independent plan developed by the HCHV program staff or as an integrated plan with the contractor.

This includes the following elements:

1. An assessment that includes the veteran's history of homelessness, mental and physical needs, substance use history, financial and legal status, and any strengths or barriers to obtaining housing
2. A treatment plan that is based on an assessment of the veteran's objectives, which may include achieving or returning to mainstream housing
3. Monthly progress notes (at a minimum) that track the veteran's progress toward his or her specific treatment plan goals, participation in treatment, and any changes to the treatment plan
4. Discharge/Exit notes that identify the veteran's personal needs for obtaining housing and continuing recovery, care, treatment, and services after exiting the program

VA Contract Performance Oversight Responsibilities

Contracting officers collaborate with medical facility CRS program staff to ensure the proposed procurement for services will meet the program's needs. The procurement must also comply with all federal and VA acquisition regulations prior to contract award. Contracting officers are responsible for taking all necessary actions for the contractors' compliance with the terms of the agreement and safeguarding the interest of the government. The Federal Acquisition Regulation (FAR) provides contracting officers the authority to enter, administer, and terminate contracts and make related determinations and findings.[21] The contracting officer also usually works with the requesting service to develop quality assurance surveillance plans that include the government's expectations and plans for evaluating the contractor's performance.

Federal regulations require contracting officers to delegate certain responsibilities in writing to contracting officer's representatives (CORs) unless contracting officers choose to retain and perform COR duties.[22] The VHA Procurement Manual explains that contracting officers, program offices, and CORs all have a role in effective oversight of contractors and ensuring satisfactory contractor performance, and it states, "CORs are required on all contracts for healthcare services."[23] The importance of complying with the VHA Procurement Manual was addressed in correspondence dated February 4, 2020, from VHA leaders to VHA's contracting staff. The correspondence states the importance of the procurement manual and notes that it is

[21] FAR 1.602-1; FAR 1.602-2.

[22] FAR 1.602-2(d) states contracting officers shall "designate and authorize, in writing and in accordance with agency procedures, a COR on all contracts other than those that are firm-fixed price, and for firm-fixed-price contracts and orders as appropriate, unless the contracting officer retains and executes the COR duties."

[23] VHA Procurement Manual, part 801.603-70, "Contracting Officer Representative SOP [Standard Operating Procedure]," March 11, 2019. Although the VHA Procurement Manual contains prescriptive language, VHA's Procurement and Logistics Office maintains that the manual contains only best practices, not requirements.

intended to provide guidance that is consistent with the VA and federal regulations from which it is derived. Further, the correspondence states that contracting staff are expected to follow the guidance contained in the procurement manual to the greatest extent practicable and that deviations should be documented and agreed to by the supervisory chain-of-command. Additionally, the handbook requires all CRS contracts to have CORs and states the contracting officer and COR will be involved in the contract administration process to include the monitoring of contractor performance through a quality assurance surveillance plan, the inspection and acceptance of supplies and services, and the processing of payments.[24]

Contracting officers issue letters of delegation authorizing the COR to monitor specific contracts. These letters set forth reporting requirements and establish the parameters for the authority of the CORs. The CORs, nominated by the HCHV program office, were typically licensed clinical social workers at the medical facilities who provided clinical services to the veterans in the CRS programs. As CORs, they also were expected to have the general competencies, relevant technical knowledge, and training (or a training plan if not yet trained) to perform the functions delegated by the contracting officer.

The delegation letter gives the COR the authority to perform certain duties, such as

- monitoring the contractor's performance quarterly in accordance with the surveillance plan, notifying the contractor of observed deficiencies, and identifying appropriate corrective actions;
- ensuring the contractor's performance is consistent with the contract terms, conditions, and work statement requirements;
- reviewing and approving contractor invoices to verify that charges for the services delivered comply with the contract terms and conditions and are acceptable;
- providing reports on contract performance to the contracting officer; and
- maintaining adequate documentation related to the contract, such as contract modifications, invoices, surveillance plan monitoring, and quarterly COR reports.

For the CRS contracts, the CORs were responsible for monitoring the contractors' performance in accordance with the terms and conditions of the contracts. Where applicable, they were also responsible for following quality assurance surveillance plans that detail how to monitor key contract requirements.[25] The handbook also required CORs, who were in many cases CRS

[24] The handbook states the COR is designated by the contracting officer and this designation shall be in writing and specify the extent of the COR's authority to act on behalf of the contracting officer.

[25] The handbook requires contracting officers, the program managers or their designees, and CORs to perform several activities during the preaward phase of the contract, including the development of a quality assurance surveillance plan. However, three of the 14 reviewed CRS contracts did not have quality assurance surveillance plans.

program staff, to complete annual and quarterly contractor evaluations and to verify the accuracy of billings for payments.

CORs were also required to submit quarterly evaluation reports that include detailed information on contractor performance, attachments to support the evaluation, and certification of invoice accuracy prior to meeting with the contracting officer.[26] The VHA Procurement Manual also states contracting officers must meet with CORs on at least a quarterly basis for all healthcare services contracts to discuss the COR's monitoring of contractor performance and administrative issues such as invoicing and payment. Furthermore, the VHA Procurement Manual states the contracting officer will summarize the meeting and have the COR acknowledge the meeting in writing. The handbook discusses specific contract monitoring requirements for CORs. It states that CORs should monitor contractor performance through the quality assurance surveillance plan and communicate any recommendations for corrective action to the contracting officer, who will then work with the contractor on compliance. The quarterly reviews and documentation of contractor performance serve as the basis for the contracting officers' formal annual performance evaluations, which affect VA's decision to replace or remain with the same contractor.[27]

The COR is generally responsible for coordinating required multidisciplinary annual inspections and following up on identified deficiencies at contractors' facilities to make certain that services are provided in a safe environment. The handbook requires an initial inspection of contracted residences before veterans are placed in the residences and annual inspections thereafter. The VA inspection team consists of medical facility staff from several areas, including clinical, facilities management, nutrition, and security, and the inspection includes reviews of the contractors' clinical documentation. If deficiencies are noted during any inspection, the contractor will typically be given 30 days to take corrective action. If corrections are not made to VA's satisfaction, the COR should notify the contracting officer to take the appropriate next steps.

Contractor Responsibilities

Medical facilities award CRS contracts to community-based agencies to provide veterans safe, substance-free, and supportive living conditions, and assistance through case management and discharge planning. There are two levels of contracted residential services: Contracted Emergency Residential Services and Low Demand Safe Havens.

Contracted Emergency Residential Services support veterans who have recently become homeless and require safe and stable living arrangements while they seek permanent housing,

[26] The handbook states that as part of ongoing monitoring activities, the COR will submit quarterly reports. "Contracting Officer Representative SOP" in the VHA Procurement Manual states that as part of COR reports, CORs should provide contracting officers quarterly evaluation reports prior to the COR meeting. While the VHA Procurement Manual contains prescriptive language, VHA's Procurement and Logistics Office maintains that the manual is only a best practice and that it is not required to be followed.

[27] CRS contracts generally have one base year and four option years VA can exercise.

whereas Low Demand Safe Havens support veterans with mental health and/or substance use disorders.

Contractors must comply with any requirements that have been set forth in the terms and conditions of the residence's contract program requirements and the handbook.[28] At a minimum, they are required to maintain

- housing and equipment in a sanitary manner;
- private restrooms that are clean and functional for the disposal of human waste;
- case management documentation for veterans, including individual treatment plans with assessments of barriers, service needs, and strengths;
- documentation of the duration and outcomes of provided services, referrals, and benefits achieved from each veteran's participation in the program; and
- a medication control system based on the method of administration—whether the medication is contractor administered, contractor monitored, or self-administered by the veteran.

Depending on the terms of each medical facility's local contracts, contractors may also be required to provide meals, mental health stabilization services, group activities, housing search assistance, and employment assistance to help veterans achieve and maintain permanent housing upon discharge. Contractors are required by federal regulations to keep all documentation for inspection for up to three years and to safeguard sensitive veteran information.[29]

[28] VHA Handbook 1162.09, *Health Care for Homeless Veterans Program*, May 2, 2014.

[29] FAR 4.703 states that contractors shall make available records, including documents to satisfy audit requirements of contracting agencies and the Comptroller General, for three years after final payment. Further, FAR 52.224-3 states privacy training shall address the key elements necessary to safeguard personally identifiable information.

Results and Recommendations

Finding 1: Improved Documentation and Monitoring Are Needed to Ensure Veterans Receive Sufficient Assistance While in Transitional Housing

Medical facility staff for some of VHA's largest CRS programs did not consistently prepare case management documentation for veterans and monitor the veterans' progress while they participated in the program. CRS staff are generally responsible for the veterans' case management, which requires regular, direct communication between the case manager, the client, and appropriate service staff. VHA requires complete documentation of veterans' case management to ensure veterans are working toward their individualized housing goals and receiving the services they need.[30] However, the audit team's review of six sampled CRS programs administered by medical facility staff, each with over $1 million in expenditures during the 12-month period ending April 30, 2019, found that 86 of 168 veterans in the programs (51 percent) lacked required case management documentation. Documentation and monitoring of the veterans varied greatly across the six programs:

- Two programs had a few documentation lapses and routinely communicated with veterans and contractor staff to monitor veteran progress.
- Two programs had more significant documentation lapses but appeared to actively monitor veterans through communication with veterans and contractor staff.
- Two programs had significant documentation and monitoring gaps during the audit review period, although one program implemented stronger monitoring controls and appeared to improve by the date of the audit team's site visit.

Medical facility CRS staff reported that inconsistencies in case management documentation and monitoring of veterans occurred due to various reasons, including workload and resource limitations. In addition, they had different interpretations as to what should be documented and what constituted sufficient monitoring. Further, according to the national director of clinical operations, the Homeless Program Office did not establish controls at the regional network or medical facility levels to identify and correct documentation and monitoring deficiencies. Due to lapses in case management documentation and patient monitoring, VHA could not always confirm that all veterans who participated in the CRS programs received the assistance and services they needed to transition to permanent housing. Based on its sample, the audit team estimated 3,400 of the 6,800 veterans (50 percent) who received transitional housing services

[30] VHA Handbook 1162.09.

through VHA's largest 24 CRS programs during the audit's review period had case management documentation and monitoring deficiencies.[31]

This finding discusses how

- CRS staff often did not prepare required case management documentation for veterans,
- CRS staff did not consistently monitor and maintain communication with veterans and residence staff, and
- Homeless Program Office controls were inadequate to ensure CRS staff compliance with the prior two requirements.

What the OIG Did

The audit team interviewed program office managers regarding the oversight, monitoring, and case management of veterans in CRS programs. The team also selected a sample of six medical facilities from the universe of 24 medical facilities that had over $1 million in contracted residential services expenditures. The sample included the Greater Los Angeles Healthcare System due to the high concentration of veterans experiencing homelessness in the Los Angeles area, and five statistically selected facilities in San Francisco, California; Tucson, Arizona; Northport, New York; New York City, New York; and Topeka, Kansas. The five medical facilities were selected from two strata—medical facilities with payments between $1 million and $2 million, and medical facilities with payments over $2 million.

The audit team reviewed the electronic health records of a total of 168 randomly selected veterans who entered the CRS programs at the six medical facilities between May 1, 2018, and April 30, 2019 (the review period). During site visits to these facilities, the team also interviewed CRS program managers and social workers to understand the challenges and effectiveness of the local CRS programs. In addition, the team conducted unannounced visits to 14 contracted residences to assess the general conditions of the residences, interview residence staff, review veterans' files at the residences, and speak with veterans.[32] Appendix A provides additional details on the audit's scope and methodology.

CRS Staff Often Did Not Prepare Required Case Management Documentation for Veterans

VHA requires CRS staff to document information in veterans' electronic health records about veteran strengths and barriers, progress toward goals, participation in treatment, and the status of

[31] The projection error rate does not equal the sample error rate due statistical sampling weights. For more information on the statistical sampling methodology, refer to appendix B.

[32] The audit team conducted site visits to the medical facilities and residences from July to November 2019, prior to the COVID-19 pandemic.

treatment goals when veterans exit the program. However, the audit team found CRS staff at the six medical facility CRS programs reviewed did not consistently prepare required case management notes in veterans' electronic health records despite the documentation requirements and expectations set forth in the handbook. CRS staff prepare these notes and work with the veterans to identify appropriate VA and community-based care providers and facilities that can provide needed services.

Regional network homeless coordinators (coordinators) the audit team interviewed generally agreed that complete case management medical record documentation is important to demonstrate due diligence and to promote continuity of care. Without required case management documentation, VHA cannot attest to the level of care or services the veterans received in the CRS program.

The audit team's review of the electronic health records of 168 veterans who were enrolled in CRS programs—28 from each of the six medical facilities—disclosed 86 veterans (51 percent) lacked required case management documentation. Table 3 shows the review results by medical facility, ordered according to the number of veterans with missing documentation.

Table 3. Sampled Veterans with Missing Case Management Documentation

Medical facility or Healthcare System	Veterans with missing documentation*	Missing assessments	Missing treatment plans	Missing progress notes†	Missing discharge plans
New York Harbor	25	0	17	18	0
San Francisco, California	22	12	21	6	0
Greater Los Angeles, California	19	6	7	15	0
Eastern Kansas	10	5	7	0	0
Southern Arizona	6	2	4	2	0
Northport, New York	4	2	4	0	0
Total	**86**	**27**	**60**	**41**	**0**

Source: VA OIG review of veteran health records in the Computerized Patient Record System.
**Each veteran could have more than one missing type of medical record documentation.*
†The handbook requires CRS staff to prepare progress notes for veterans when clinically indicated and at least once a month. The audit team considered documentation to be missing if veterans did not have at least one progress note a month during their stays in the residences.

Based on these results, the team estimated 3,400 of the 6,800 veterans (50 percent) who received transitional housing services through VHA's largest 24 CRS programs during the audit's review period lacked the required case management documentation. CRS staff at the six reviewed programs could not show that they had fully attempted to assess and address the veterans' treatment needs and monitored the veterans' progress as required by VHA policy. Appendix B provides additional details on the statistical projections.

The handbook also states treatment plans are a required component of CRS case management services to ensure continuity of care. However, the audit team's review found treatment plans were the most common missing case management document from the electronic health records of the reviewed veterans.

The audit team did not identify a strong correlation between the lack of case management documentation and the success of 86 veterans in the program—39 veterans completed the program and obtained permanent housing and 47 veterans did not.[33] However, case management documentation is still important to providing continuity of care. Veterans have complex needs and over time may need the assistance of different VA transitional housing programs or the same program multiple times as they seek permanent housing. For example, the audit team found that 14 of the 86 veterans who lacked adequate case management documentation had returned to the CRS program or another VA transitional housing program one or more times during the eight-month period from May 1 through December 31, 2019.[34] Subsequently, the CRS programs addressed these veterans' immediate needs for shelter, but the lack of adequate case management documentation could potentially inhibit the program managers' ability to ensure staff provide veterans the needed care and services to optimize their treatment and housing outcomes. Furthermore, the incomplete case management documentation meant that VHA homeless program staff lacked treatment history information about barriers to the delivery of care and the efficacy of treatment interventions. That information could help inform future actions if veterans return for additional homelessness assistance.

CRS Staff Did Not Consistently Monitor and Maintain Communication with Veterans and Residence Staff

VHA's Handbook 1162.09 does not clearly define the frequency of contact that CRS staff should have with veterans or contractor residence staff to monitor veterans while they are in the program, other than that CRS staff at a minimum should maintain monthly progress notes to track veterans' progress. Thus, CRS staff at four of the reviewed facilities communicated

[33] The 47 veterans (55 percent) exited the program without successfully obtaining permanent housing for various reasons, such as violations of program rules, the need for a higher level of care, or a personal decision to leave the program without consulting the program staff.

[34] These veterans also sometimes received transitional housing assistance through VA's Grant and Per Diem or Domiciliary Care for Homeless Veterans programs.

regularly with veterans and contract staff at residences to monitor veteran care, while staff at two of the reviewed medical facilities did not. The audit team found that CRS staff at VHA's Southern Arizona, Northport, New York Harbor, and Eastern Kansas medical facilities held structured weekly in-person meetings or telephone case management calls with veterans and contract social workers to discuss each veteran's progress. Southern Arizona and Northport CRS staff routinely documented their meetings and calls in veteran medical records. CRS staff at New York Harbor and Eastern Kansas stated they did not consistently document their meetings or calls with veterans or the contractors in the medical records unless there were significant updates or events requiring attention. Despite these documentation lapses, the audit team found the New York Harbor and Eastern Kansas CRS staffs' assertions that they maintained routine communications with veterans and contract staff credible. Residence staff corroborated during interviews that the CRS staff visited weekly, or at least a few times a month, to meet with them and the veterans to discuss progress. The four facilities where staff routinely held meetings with residence staff had smaller CRS programs with fewer veterans and lower staff turnover than the two other facilities in the team's sample.[35] These factors appeared to help staff maintain better monitoring and communication with program participants.

The Greater Los Angeles CRS program had documentation deficiencies and did not appear to be consistently monitoring and maintaining communication with veterans during the audit review period. However, by the time the audit team visited the medical facility in August 2019, the program had implemented similar controls to those at Southern Arizona, Northport, New York Harbor, and Eastern Kansas to make sure regular monitoring and communication occurred with contractors about veterans. The audit team confirmed that the Greater Los Angeles CRS program began implementing these controls after an April 2018 Homeless Program Office audit identified several areas where the program did not meet handbook requirements. According to the national director of clinical operations, the Homeless Program Office began providing functional direction to the Greater Los Angeles homeless programs in 2017. The medical facility requested direction due to the loss of key senior staff and an increase in veterans experiencing homelessness, and the intent of the program office audit was to identify areas for improvement.[36] The program office audit found that Greater Los Angeles CRS staff did not maintain direct communication with veterans in the program and that contact primarily occurred when residence staff called CRS staff to request a service, such as a referral for a veteran to other VA homeless programs or services. The program office audit also found the facility's CRS staff were not completing the required documentation for individualized treatment plans, assessments, or

[35] Additional transitional housing beds for veterans can be provided through other VA homeless programs, such as Grant and Per Diem, or other local resources such as city shelters.

[36] A memorandum between the Homeless Program Office and the medical facility was established on October 18, 2019, to formalize the program office's role of providing functional direction. However, this memorandum expired on January 18, 2020.

monthly follow-ups. After the program office audit, the medical facility CRS program hired more staff starting in late 2018 and conducted additional training.

By August 2019, when the audit team interviewed four Greater Los Angeles CRS staff members, the staff stated they visited contractors between two times a month and a few times a week, depending on the distance of the residence from the medical facility. For example, one CRS staff member visited a contractor about 60 miles away two to three times a month. The audit team reviewed electronic health records for a random selection of veterans who stayed at three of the four CRS residences during the team's visit and confirmed CRS staff had frequent interactions and regular visits.[37] All four of the Greater Los Angeles CRS contractors the audit team visited confirmed the CRS staff conducted regular visits, at least every 30 days, and one contractor reported it had begun maintaining better veteran records as a result of the increased monitoring. In addition, the four contractors reported that CRS staff were responsive to their inquiries and all contractors cited a collaborative working relationship where they had frequent interactions with CRS staff and could rely on the CRS staff's assistance with veterans who were not complying with the residences' rules.

CRS staff at the San Francisco VA Medical Center appeared to have the least contact and direct communication with veterans and residence staff compared to the programs at the other five medical facilities. The audit team found that case load assignments at the San Francisco medical center made it difficult for CRS staff to effectively monitor veterans because staff were assigned to work with veterans in up to seven different residences, as opposed to the other five reviewed medical facilities where staff worked with veterans in only one or two contracted residences. Additionally, one CRS staff member noted that although she encouraged veterans in her caseload to develop treatment plans with her, she generally did not follow up with veterans who failed to show up for their scheduled appointments. She said she remained available if veterans chose to follow up later.

Staff at two of the four San Francisco residences reviewed believed that communication and coordination with the CRS staff could be improved. The director for clinical services at one residence indicated there was a lack of structured meetings between residence and CRS staff because residence staff did not always know when VA staff visited. This director believed that a better system of communication, such as brief meetings between residence and VA staff and regular communication with veterans' VA social workers, could help reduce duplication of services. The director at another contracted residence stated that CRS staff started visiting regularly for monthly meetings with the residence staff to discuss veteran progress after the audit team's site visit.

[37] Three of the four HCHV contractors reviewed from the Greater Los Angeles Healthcare System CRS program had veterans who entered in April 2019 and exited in August 2019 or later. The audit team found active case management documented in the electronic health records for all 12 veterans who met these criteria.

Management staff at the San Francisco medical center also reported after the audit team's site visit that the CRS program was fully staffed as of February 2020, and it had started piloting a model of having one CRS social worker assigned to each contracted residence to improve efficiency.

Example 1 illustrates how the absence of case management documentation may indicate possible lapses in monitoring.

Example 1

In fall 2018, a veteran experiencing homelessness in San Francisco wanted to address his substance use and was placed in a CRS program that offered treatment. However, the CRS social worker responsible for the veteran's care after his placement in the program did not prepare a treatment plan with goals and objectives, which would have included the need to treat the veteran's substance use.[38]

About two months after the veteran's admission to the program, another resident reportedly assaulted the veteran and gave him a bleeding gash above his right eye. The contractor did not report this incident to the medical facility or the CRS social worker even though it was required by the contract. VA medical facility staff only appeared to become aware of the incident in early winter 2019 when the veteran reported to his VA mental health provider that he began drinking heavily after the assault. About two weeks after the veteran met with his VA mental health provider, the veteran was discharged from this residence for drinking and possessing open bottles of alcohol.

The audit team could not locate any CRS progress notes in the veteran's electronic health record that discussed the assault. Thus, it appeared the CRS social worker was unaware of the assault until the audit team informed her of it during the team's site visit in summer 2019. Furthermore, the audit team could not confirm from its review of the veteran's medical record if the CRS social worker ever met with the veteran while he was at the residence to check on his progress toward sobriety and his housing goals. The veteran reentered the CRS program two additional times after this discharge and achieved permanent housing five months later.

[38] According to the homeless program supervisor, CRS social workers at the San Francisco VA Medical Center's downtown clinic perform intake assessments for veterans who walk in and refer these veterans to the appropriate CRS program based on their clinical needs. Once a veteran is placed, another CRS social worker responsible for case management is assigned to the veteran.

CRS social workers at the six reviewed facilities provided a variety of reasons for not consistently documenting required assessments, treatment plans, monthly progress notes, or discharge plans for veterans, such as high workload, limited available time, and brief or routine discussions with veterans that did not need to be documented.

Homeless Program Office Controls Did Not Ensure CRS Staff Consistently Monitored Veterans and Completed Case Management Documentation

VHA's Homeless Program Office did not establish Veterans Integrated Service Network and medical facility oversight mechanisms to promote the consistent monitoring of veterans in medical facility CRS programs and completion of required case management documentation.

The Homeless Program Office assigned responsibilities to various VHA officials and staff and established requirements for the implementation of the CRS program in the handbook. The Homeless Program Office provided the field technical assistance and recommended corrective actions when it evaluated the facilities' performance relative to the CRS performance targets, exits to permanent housing, and negative exits. As demonstrated by its agreement with the Greater Los Angeles medical facility, the Homeless Program Office will under certain circumstances help a CRS program that is experiencing significant operational challenges, such as the loss of key staff members. However, according to the national director of clinical operations, the Homeless Program Office generally focuses on whether facilities meet CRS performance targets, not on the local control processes and procedures needed to achieve them at a specific medical facility. The national director further stated that the program office relies on network homeless coordinators and CRS program managers to establish these processes for individual facilities.

The audit team found that the coordinators also monitored the medical facilities' progress toward the CRS performance targets. According to the coordinators, they provided guidance to the medical facilities and answered their questions, but did not include case management documentation preparation, monitoring, or communication in their oversight activities unless specific incidents or problems came to their attention. CRS program managers at medical facilities with more documentation issues did not routinely monitor and review the preparation of case management documentation throughout the year, and instead had conversations with CRS staff about specific veteran cases when contractors and CRS staff brought questions to their attention.

Following the audit team's site visits, the Homeless Program Office informed the audit team in January 2020 that the program office had begun developing a tool for coordinators to audit all homeless programs, including the CRS program. The audit tool includes the CRS case management documentation requirements from the handbook. The OIG audit team's review of the draft audit tool noted that coordinators will be expected to do a comprehensive review of the

completeness of veteran medical record documentation and contract files, as well as the adequacy of provided clinical services that were required by contracts. In addition, the coordinators will evaluate the adequacy of CRS staff oversight, such as whether CRS staff actively participated in reviews or case conferences with contractor staff and veterans. This type of monitoring at the Veterans Integrated Service Network level could help identify and correct many of the documentation and monitoring issues the audit team found if it is consistently and properly implemented and used.

Finding 1 Conclusion

The audit team estimated 3,400 of the 6,800 veterans (50 percent) who received transitional housing services through VHA's largest 24 CRS programs during the audit's review period had case management documentation and monitoring deficiencies in their records. Addressing these deficiencies would help VA ensure medical facilities and CRS contractors provide veterans the optimal services for helping them achieve their independent living and permanent housing goals. The Homeless Program Office should implement an oversight mechanism to monitor compliance with documentation requirements and the completion of corrective actions.

Recommendation 1

The OIG made the following recommendation to the acting under secretary for health:

1. Establish control mechanisms at the Veterans Integrated Service Network and Contracted Residential Services program levels to ensure Contracted Residential Services staff at medical facilities comply with Veterans Health Administration Handbook 1162.09 requirements for monitoring and documentation.

Management Comments

The acting under secretary for health concurred with recommendation 1. To address the recommendation, he stated that the HCHV program office will develop an oversight tool for network homeless coordinators to ensure they comply with veteran monitoring and documentation requirements in Handbook 1162.09. Appendix D contains the full text of the acting under secretary's comments.

OIG Response

The OIG will monitor implementation of the action plan for recommendation 1 and will close this recommendation when the OIG receives sufficient evidence to demonstrate the cited corrective action has been implemented.

Finding 2: Stronger Monitoring of Contractor Performance and Contract Administration Is Needed to Safeguard Veteran and Government Interests

Annual inspections are required by the HCHV program to ensure contractors meet quality standards. COR quarterly evaluations also provide assurance that contractors meet the other terms and conditions of their contracts. However, annual inspection teams and CRS staff, who also served as CORs at many of the visited sites, did not always check that contractors met CRS program and contract requirements using established inspection and evaluation processes.[39] The audit team found that staff at four of the reviewed medical facilities did not confirm that four of the 14 CRS contracts reviewed (about 29 percent) met performance requirements. One of these contracts had improper payments possibly totaling as much as $592,000 because the contractor failed to maintain veteran case records to show veterans were actively engaged in therapeutic and rehabilitative services as required by the terms of the contract.[40]

The audit team also found contract administration problems in 13 of 14 reviewed CRS contracts (about 93 percent) at the six reviewed medical facilities.[41] The team found contracting officers did not always properly delegate responsibilities to staff who functioned as CORs, invoices lacked required supporting documentation, two contracts were not modified to reflect changes in the scope of work, and invoices contained billing errors. These issues led to improper payments. For payments made where COR delegations were missing, the team determined the payments were technically improper. Technically improper payments are made to the right recipient in the correct amount, but the payment process does not follow the pertinent regulation or statute.[42] In total, the contract administration issues led to improper payments totaling an estimated

[39] CRS staff at five of the reviewed facilities served as CORs and participated in the residence inspections and site visits. The COR for the Greater Los Angeles Healthcare System CRS program was not a CRS staff member and did not participate in inspections.

[40] OMB Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. The circular states, "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." An improper payment also includes any payment for goods or services not received. When an agency's review is unable to discern whether a payment was proper due to insufficient or lack of documentation, even if there is no monetary loss, the payment must also be considered improper. The team used the total contract payments for the review period to estimate an upper limit for the improper payments because the contract did not have any data or information that could be used to estimate the cost of the therapeutic and rehabilitative services included as part of the contract's per diem rate.

[41] Of the 13 contracts reviewed that had contract administration problems, four also had performance deficiencies.

[42] According to the *FY 2019 OMB Paymentaccuracy.gov Data Call Instructions*, a technically improper payment is a payment to the right recipient for the right amount, but the payment process fails to follow applicable statute or regulation. Additionally, OMB Circular A-123, app. C, "Requirements for Payment Integrity Improvement," March 5, 2021, includes the definition of technically improper payments. Although the time frame of this audit preceded the March 2021 circular, the payments at issue are technically improper under both the *FY 2019 OMB Paymentaccuracy.gov Data Call Instructions* and the circular.

$7 million, of which about $6 million were technically improper payments and nonmonetary losses to the government.

These contract monitoring and administration problems occurred for the following reasons:

- CRS staff notified contractors in advance of annual and quarterly inspections, potentially giving contractors ample time to fix some problems before the inspections but not ensuring correction of deficiencies in the long term.
- Contracting officers either did not ensure that quality assurance surveillance plans were included in contracts or, when they were included, did not make sure CORs used them to identify contract performance issues.[43]
- Contracting officers did not hold and document quarterly meetings with CORs to discuss and evaluate contractor performance, adherence to contract requirements, and invoicing and payments.
- The Network Contracting Office did not ensure contracting officers issued letters of delegation after medical facilities nominated individuals to be CORs or use peer review to identify when letters of delegation were missing.
- Guidance in the *Health Care for Homeless Veterans Program Handbook* did not address administrative practices such as payments to contractors when veterans are absent from their residences.

Based on its review of the 14 contracts, the audit team estimated that 107 of the 119 contracts belonging to VHA's largest CRS programs had contract performance and administration problems. Furthermore, based on the $7.6 million in improper payments identified in the contracts reviewed, the team estimated VHA made $35.3 million in improper payments, of which approximately $21.6 million were technically improper payments because the individuals who authorized the payments were not delegated with COR authority. Appendixes B and C provide more information on the statistical sampling methodology and monetary impact.

This finding addresses three issue areas in more detail:

- Inadequate monitoring of contractors' performance increased risks to veteran care and led to improper payments.
- Inadequate contract administration practices placed veteran and taxpayer interests at risk and led to improper payments.

[43] FAR 46.401(a) states quality assurance surveillance plans should be prepared in conjunction with the preparation of the statement of work and specify all work requiring surveillance and the method of surveillance. Surveillance plans are an important tool for CORs to effectively monitor the quality of the services received and compliance with the terms of the contract.

- Homeless Program Office personnel and network contracting officials did not ensure contractors were properly monitored and contracts were adequately administered.

What the OIG Did

The audit team reviewed the applicable CRS contracts and expenditures associated with 168 sampled veterans from the six selected VA medical facilities during the audit's review period. In total, the medical facilities expended about $18.9 million to operate their CRS programs and provided about 1,800 veterans transitional housing during the review period. The team examined up to four contracts at each selected medical facility based on the facility's total number of awarded CRS contracts. Subsequently, the team reviewed a sample of 14 contracts, the annual inspection reports, and quarterly evaluation reports for the associated contracted residences to evaluate the medical facilities' monitoring of the CRS contractors. To assess the accuracy of the contract payments, the team reviewed payment documentation for 28 veterans at each facility who entered the contracted residences during the review period. For improper payments identified, the team projected the amounts from the contracts reviewed from the six selected medical facilities to the 24 medical facilities with the largest CRS programs by expenditures.

Inadequate Monitoring of Contractors' Performance Increased Risks to Veteran Care and Led to Improper Payments

Medical facility staff from several disciplines, including clinical, facilities management, nutrition, and security, are responsible for conducting annual inspections of each contractor's residences. The audit team generally found CRS social workers, who also functioned as CORs, helped coordinate annual inspections and were part of the inspection teams. In addition, the CORs were responsible for conducting quarterly evaluations of the contractors and meeting with the contracting officers to review the contractors' performance. However, the audit team found deficiencies during its unannounced site visits that the inspection teams and CORs did not always identify during their inspections. In cases where they did identify deficiencies, CORs did not always check that the residences sustained the corrective actions.

The audit team's unannounced visits to the residences identified unsanitary areas within the residences, missing contractor case management documentation, and inadequate medication storage at four of the 14 reviewed residences (about 29 percent). In these cases, the annual inspections or quarterly evaluations failed to address the deficiencies. These deficiencies could affect the health and safety of veterans living in group settings. Further, VA lacks assurance veterans received services required by the contracts. The audit team's review of the annual

inspection reports and quarterly contractor evaluations for the 14 contract residences from the review period of May 2018 to April 2019 found

- three cases where neither the inspection nor the evaluations identified the problems found during the OIG audit team's unannounced site visit;
- two cases where the inspection identified the problem, but the evaluations completed prior to the OIG audit team's visit had not; and
- one case where the inspection and the evaluations cited the problem and HCHV program staff were still working with the contractor to resolve the issue.

Table 4 lists the residences in descending order based on the number of OIG-identified deficiencies and shows the conditions the audit team identified at residences during its unannounced visits, results from its review of the residences' annual inspections and contract evaluations, and discussion of the results of the unannounced site visits with the CORs. Each OIG-identified deficiency is then detailed for each of the facilities in the discussion that follows.

Table 4. Comparison of OIG-Identified Deficiencies and Prior Annual Inspection and Evaluations Results

Medical facility and residence	OIG-identified deficiencies	Identified by annual inspection	Identified by quarterly evaluation	COR response to identified deficiency
San Francisco—Next Door Shelter	Unsanitary residences	No	No	Aware of conditions and was working with the residence to address the problem but did not report the issue.
	Missing documentation	Yes	Yes	Reported the missing documentation to the contracting officer but did not receive guidance. Local CRS office was working with residence to resolve.
Southern Arizona—Old Pueblo Rapid Emergent Housing	Unsanitary residences	Yes	No	Unaware of current issue and had not identified it during quarterly evaluations.

Medical facility and residence	OIG-identified deficiencies	Identified by annual inspection	Identified by quarterly evaluation	COR response to identified deficiency
	Unsecured medications	Yes	No	Unaware of current issue and had not identified it during quarterly evaluations.
New York Harbor—Patriot First	Unsecured medications	No	No	Issue excluded from annual inspection. Spot checks of veterans' rooms had not identified the issue.
Eastern Kansas—Rose Villa Hope House	Missing documentation	No	No	Unaware of issue and notified residence in advance of visits.

Source: VA OIG analysis of annual inspections, quarterly evaluation reports, and interviews with CORs.

The CORs interviewed from Southern Arizona, New York Harbor, and Eastern Kansas stated they typically visited the residences weekly, while the CORs at San Francisco indicated they visited at least quarterly and had weekly calls with the contractors. The CORs at all four medical facilities stated that they conducted chart reviews, checked sign-in sheets, generally observed conditions on-site at the residences, and made clinical observations based on the veterans' treatment to complete the required contractor evaluations. Furthermore, they stated that they considered direct input from veterans who received services during the quarter and frequent discussions with residence staff as relevant factors in the completion of their quarterly evaluations. Subsequently, the four CORs completed the annual and quarterly evaluation forms for the contractors as required by the handbook, but some evaluation areas, such as assessing significant reportable contract performance issues, required the CORs to use their judgment. Thus, the audit team found that two CORs stated they reported all known contract deficiencies, one stated she reported only critical or ongoing issues, and one stated he only reported important issues if the residences were not working to address them.

San Francisco Inspection and Evaluations Did Not Ensure the Correction of Known Deficiencies

The audit team identified two issues at the Next Door Shelter residence in San Francisco during its unannounced site visit in July 2019. The team found dried feces in a communal restroom of the Next Door Shelter residence and determined that the residence did not have case management documentation for any of the seven veterans sampled from the program. The unsanitary restroom appeared to be part of an ongoing sanitation problem at the residence. A

local governmental agency notified the residence on June 4, 2019, that it had discontinued the residence's funding due to unsanitary conditions it had identified during inspections in November 2018 and April 2019. Despite the local agency's findings, the medical facility's annual inspection conducted in November 2018 and the three quarterly evaluations completed prior to the audit team's visit did not identify any sanitation issues. When the audit team discussed the unsanitary conditions with the COR, he disclosed that he was aware of the conditions, but he did not report them because he was working with residence staff toward a resolution. The audit team concluded that the COR still should have reported this performance deficiency to the contracting officer because the residence was only cleaning the restroom once a day, even though the terms of the contract required twice-daily cleanings.

In addition, the Next Door Shelter residence failed to maintain case management documentation, even though an annual inspection team identified documentation as a problem in November 2018.[44] The COR also identified it as a contract performance deficiency in the March 2019 quarterly evaluation and provided the residence a case management documentation template for its use. Nevertheless, the contracting officer did not follow up with the contractor to ensure the reported deficiency was corrected. During the OIG audit team's unannounced visit in July 2019, the team found the residence still was not preparing case management documentation. According to the COR, the contractor still lacked case management documentation as of August 2019 due to a staffing shortage at the residence. However, a new COR issued a Contractor Discrepancy Report, an official letter notifying the contractor of noncompliance with a contract term, to the Next Door Shelter residence in November 2019. The report stated the residence had still not fully complied with requirements to maintain case management documentation. The contractor responded in December 2019 that significant procedures had been put in place to resolve the discrepancy, and that it had updated and maintained participant records and was prepared to provide examples to the VA COR during the next visit. Although the contractor reportedly hired a dedicated case manager in January 2020 and finally met the contract's documentation requirements, the COR informed the audit team that the medical facility terminated the contract on July 31, 2020, because the contractor's services were no longer needed.

Southern Arizona Evaluations Did Not Note Sanitation and Medication Storage Concerns

The audit team found unsanitary conditions including dirty vents, full trash bins, and dead bugs in a communal kitchen shared by four veterans, and unsecured self-administered medications in a

[44] The audit team determined that the lack of case management documentation by this contractor led to improper payments. However, the contracting officer also did not properly delegate authority to the individual functioning as the COR for this contract. Thus, to avoid double counting, the team categorized these contractor improper payments as part of the $6 million in improper payments associated with the absence of COR delegations in table 5.

veteran's shared bedroom at the Old Pueblo Rapid Emergent Housing residence during the team's unannounced site visit in September 2019.[45] The medical facility's annual inspection in November 2018 also identified sanitation and medication storage issues, and the contractor reportedly remediated these deficiencies and reeducated one veteran on the residence's medication storage policies at that time.

The COR's three quarterly evaluations performed after the annual inspection and prior to the OIG audit team's site visit did not identify any sanitation or medication storage deficiencies. The COR, who also served as the CRS contract housing liaison and social worker, stated that her quarterly evaluations were based on her observations and discussions with contract staff and veterans at the residences during her visits, and whether veterans had complaints. When the team discussed the deficiencies identified during its unannounced site visit, the COR stated she was unaware of the issues the audit team found. She also stated she felt the veterans had to learn how to live independently and that it was up to them to learn how to clean up after themselves and to secure their own medications as part of that. The COR further stated it was difficult to make sure veterans comply with house rules such as appropriately disposing of trash and locking up their medications.

Although the COR's statements were reasonable given her experience as a housing liaison and social worker who provides clinical services to veterans in the CRS program, the COR is responsible for assessing the contractor's performance relative to the contract's requirements during evaluations. Under the Old Pueblo Rapid Emergent Housing residence contract, the contractor is responsible for the safety and cleanliness of the residence and, regardless of the challenges, engaging veterans in the maintenance of a clean, safe, and sober environment. The contract requires the contractor to establish sanitary procedures, encourage veterans to engage in the cleaning and upkeep of the facility, provide a safe and sober environment for all veterans, and help veterans learn how to successfully live independently. Consequently, the COR should have at least considered sanitation and medication storage issues and the contractor's efforts to engage veterans in resolving these issues when she evaluated the contractor's performance.

New York Harbor Inspection and Evaluations Did Not Address the Unsecured Storage of Medications in Veterans' Rooms

The audit team found unsecured self-administered medications in an apartment shared by six veterans at the Patriot First residence during its unannounced site visit in October 2019. The contract requires that the residence staff maintains a safe and sober environment. Annual inspection teams are required to verify whether self-administered medications are stored in accordance with contract requirements and the handbook. The annual inspection form in the

[45] Unsecured medications must be avoided because they pose potential safety issues in communal living settings where residents may have substance use disorders.

handbook includes a section on self-administered medication storage practices in veterans' rooms. However, the Patriot First's annual inspection team marked the medication review as "not applicable" on the FYs 2018 and 2019 CRS annual inspection forms, completed in November 2017 and October 2018.[46] While the audit team could not conclude that unsecured medications were a persistent problem at this residence, the COR stated the annual inspection team did not conduct a medication review because she was new to the position at that time and initially interpreted this section of the annual inspection checklist as not applicable because the veterans are responsible for storing their own medications.

Contractor residence staff stated that they performed routine announced inspections of the communal areas, such as bathrooms, living rooms, kitchens, and bedrooms. However, they stated it was difficult to ensure veterans continuously locked their medications because the veterans would secure the medications when they knew the inspections were occurring. The contract's statement of work indicates the contractor is responsible for ensuring the safe storage and handling of prescription medications in the residence, including prescribed controlled substances.

Prior to the audit team's visit, the annual inspection team did not check for the proper storage of medications, and the COR stated that she only occasionally conducted spot checks. The COR did not routinely check for medication storage issues during the quarterly evaluations even though the COR is required to attest that all services were provided in accordance with the contract's statement of work. After the audit team's visit, the COR stated that she now understood the annual inspection teams should check veterans' rooms for proper storage of medications, and she has begun checking each room monthly to prepare for the quarterly evaluations.

Eastern Kansas Inspection and Evaluation Weaknesses Hindered the Detection of Case Management Documentation Deficiencies

The audit team found the Rose Villa Hope House could not produce individual case records showing therapeutic and rehabilitative services were provided to any of the 28 sampled veterans during the team's unannounced site visit in November 2019. This documentation should have been readily available for the audit team's review because the contract required that 98 percent of the individual case records include documentation that the veterans were actively engaged in available therapeutic and rehabilitative services. Despite these requirements, the July 2019 annual inspection and the prior three quarterly evaluations did not identify any documentation gaps. In addition, the COR attested in the quarterly evaluation reports that the residence complied with all the contract's documentation requirements.

The COR stated she was unaware of the documentation deficiencies the audit team identified. However, she acknowledged that she notified the residence in advance of the annual inspections

[46] Federal government fiscal years begin on October 1 and end on September 30 of the next calendar year. Accordingly, FY 2019 began in October 1, 2018.

and said she allowed the contractor's staff to choose which veterans, from those residing there at the time, would have their records reviewed. Based on the COR's admission that the contractor was notified in advance of the details of the inspection and the audit team's review results, the audit team concluded that the flawed Eastern Kansas CRS annual inspection process may have allowed the contractor's clinical documentation deficiencies to go undetected.

The weakness the audit team noted in the facility's annual inspection of the residence also undermined the facility's quarterly evaluations. The COR stated that, based on the chart reviews completed during the annual inspection and the weekly clinical discussions she had with the residence staff about each veteran, she did not feel the need to formally evaluate the contractor's case records further during the quarterly evaluations.

Finally, the lack of individual case records showing therapeutic and rehabilitative services were provided to the 28 sampled veterans at Rose Villa Hope House also prevented the audit team from verifying that the contractor had provided these services as required by the contract. Thus, the audit team determined that the payments for these veterans were improper payments for services not received. The contract is firm-fixed price, and therefore, does not itemize the value of therapeutic and rehabilitative services. Thus, the team could not determine how much of the total contract payments were for these services. The audit team estimated that as much as $592,000 of the contract payments from the review period are improper payments due to insufficient individual case record documentation, but these improper payments are not recoverable since the specific value of the therapeutic and rehabilitative services could not be determined.[47]

Inadequate Contract Administration Practices Placed Veteran and Taxpayer Interests at Risk and Led to Improper Payments

The audit team found deficiencies in the administration of 13 of the 14 contracts reviewed (about 93 percent) that resulted in improper payments totaling an estimated $7 million, of which about $6 million were technically improper payments and nonmonetary losses to the government

[47] The Next Door Shelter, discussed earlier, also did not maintain case management documentation. However, the contracting officer failed to delegate a COR for the Next Door Shelter contract. To avoid double counting, improper payments related to the Next Door Shelter contract are included in the next section on inadequate contract administration.

(related to individuals who did not have delegated COR authority).[48] The improper payments stemmed from multiple factors:

- Medical facility staff functioned as CORs without delegations of authority, yet they approved invoices for payment, contributing to $6 million in technically improper payments and nonmonetary losses.
- CORs did not always obtain supporting documentation for contract invoices, resulting in $664,000 in improper payments. These improper payments were not recoverable because the absence of supporting VA documentation prevented the calculation of the amount of the monetary loss.
- A CRS contract was not modified to reflect desired changes in the scope of work, leading to $306,000 in improper payments. These improper payments were not recoverable because the value of the services the contractor provided under the changed scope of work could not be calculated and considered in the calculation of the monetary loss.
- CORs did not identify incorrect CRS contractor billings, totaling $7,500 in improper payments. These improper payments were recoverable, but the OIG did not recommend VHA recover these payments due to their immaterial amount.

According to the FAR and the handbook, the COR is responsible for monitoring and ensuring satisfactory contractor performance.[49] However, the team found that contracting officers did not designate and authorize CORs in writing to manage and oversee seven of the 14 sampled

[48] The audit team also identified a contract administration issue for this contractor related to invoice overpayments. Therefore, this contract and associated invoice overpayments are included as part of the 13 contracts totaling $7 million in contract administration improper payments. However, the $592,000 in contract monitoring improper payments related to incomplete documentation of therapeutic and rehabilitative services at the Eastern Kansas contractor are separate from the contract administration improper payments. OMB Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018, states, "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. An improper payment also includes any payment for goods or services not received. When an agency's review is unable to discern whether a payment was proper due to insufficient or lack of documentation, even if there is no monetary loss, the payment must also be considered improper."

[49] FAR 32.905 states, "Payment will be based on receipt of a proper invoice and satisfactory contract performance." VHA Handbook 1162.09, *Health Care for Homeless Veterans Program*, May 2, 2014. The handbook states that as part of contract administration, the COR is responsible for monitoring contract performance.

contracts (50 percent) as required.[50] As a result, six CRS social workers at the San Francisco, Greater Los Angeles, and New York Harbor medical facilities functioned as CORs for seven contracts even though they did not have the authority to monitor the contractors' performance and to approve invoices for payment. In addition to not complying with federal regulations that require contracting officers to delegate their authority in writing, the absence of a letter of delegation from the contracting officers means VA lacked assurance that these individuals were aware of contract terms and monitoring requirements to safeguard the government's interests and resources. It is imperative that contracting officers designate and authorize CORs in writing and identify their specific duties, responsibilities, and limitations to protect the government's interest for each contract they manage and oversee. Due to the lack of COR delegation letters, the audit team found that CRS social workers improperly approved invoices for seven contracts, leading to technically improper payments totaling about $6 million, because they did not have the authority to approve the invoices for payment. Table 5 shows the breakdown of the technically improper payments by medical facility, in order of magnitude.

Table 5. Technically Improper Payments Due to Lack of Proper COR Delegations

Medical facility	Improper payment amount
Greater Los Angeles, CA	$3,100,000
New York Harbor, NY	$2,400,000
San Francisco, CA	$508,000
Total	**$6,000,000**

Source: VA OIG analysis of sampled contractor payments.
Note: Figures do not sum to the total because they are rounded for reporting purposes.

Northport VA medical facility CORs did not require one of the contractors to submit invoices with contractually required documentation, such as daily sign-in sheets and/or signatures, to validate occupancy of every bed billed during the month. Although the contract and one of the surveillance plan's performance standards required the contractor to provide daily sign-in sheets of veterans to verify bed occupancy, neither the medical facility nor the contractor maintained daily sign-in sheets to support the billed invoices. The medical facility had case management and attendance records to demonstrate the veterans had been in the residence, but the documentation

[50] FAR 1.602-2(d) states that contracting officers shall designate and authorize, in writing and in accordance with agency procedures, a COR on all contracts other than those that are firm-fixed price, and for firm-fixed-price contracts and orders as appropriate, unless the contracting officer retains and executes the COR duties. Although the contracts at issue were firm-fixed price, the contracting officer did not retain and execute the COR duties at issue. Instead, individuals were allowed to act as CORs without the required written delegation. VHA Handbook 1162.09 states that the COR is designated by the contracting officer and this designation shall be in writing and specify the extent of the COR's authority to act on behalf of the contracting officer. Further, the handbook also requires the COR to review the accuracy of the billing.

was insufficient to show occupancy in the residence during all the billed days, which was a contract requirement. Therefore, the audit team classified the total payments of about $664,000 as improper payments but determined the amount was not recoverable.

CORs at the Southern Arizona medical facility did not make certain that the two contractors followed the meal requirements in their contracts. One contractor that was required under the contract to provide veterans with three daily nutritious meals did not, and the COR explained the veterans were expected to make their own meals to help develop their living skills. However, the contract did not state this was an alternative to the contractor providing the veterans three daily nutritious meals. The other contractor was required to provide veterans with three daily meals or provide the means to purchase and prepare their own meals. Instead, the contractor stated it provided occasional meals and offered periodic transportation for veterans to grocery stores where veterans would buy groceries with their own income or food stamps. However, the contractor was not in compliance with the contract because the contractor stated it would only provide the means for groceries if the veterans did not have any income or food stamps.

When the OIG audit team asked about these contract deviations, the current and previous CORs agreed that modifications should have been issued for both contracts. However, the previous contracting officer, COR, and HCHV staff had decided the practices did not deviate significantly enough from contract requirements to warrant modifications, according to the current COR. The contracting officer stated that the alternate meal arrangements were thought to promote independent living. As a result, VA made improper payments of about $306,000 for services it never received because the contracting officer, COR, and HCHV staff chose neither to enforce the terms of the contracts nor modify the contracts to relax the requirements.[51]

Medical facility social workers and CORs for eight of the 14 sampled contracts (57 percent) did not ensure contractors accurately billed VA for services, leading to improper payments. The team found that contractors erroneously billed VA for days veterans were not present, such as after the date of discharge, or for days beyond the contractually allowable number of absences. The audit team's reviews of contracts also found that some contracts allowed billing for a limited number of absences while others did not state VA would pay for absences, potentially leading to confusion. The audit team's review of the billing terms in the 14 sampled contracts and the contractors' invoices and supporting attendance documentation disclosed that five of the reviewed medical facilities made improper payments to seven contractors for absences that were not allowed under the terms of their contracts. This resulted in about $7,500 in improper payments.

[51] The audit team was able to calculate the improper payment amount based on the contractor's pricing proposals, which identified the portion of the per diem rate associated with meals. However, the team could not calculate the specific amount that was recoverable because it could not calculate the value of the meals and groceries the contractor provided in lieu of the three daily meals specified in the contract.

VA must confirm medical facility social workers who are expected to monitor CRS contracts receive COR delegations in accordance with the FAR and VA policy so that contracting officers can monitor and hold contractors accountable. In addition, CORs must review required documentation when approving invoices and ensure invoices are paid accurately and in accordance with contract terms. Stronger contract administration would protect taxpayer interests and prevent improper payments.

Homeless Program Office Personnel and Network Contracting Office Officials Did Not Ensure Contractors Were Properly Monitored and Contracts Were Adequately Administered

Network Contracting Office officials responsible for the award and administration of the 14 reviewed HCHV contracts did not adequately oversee and monitor the CORs and contractor residences. These officials include the Network Contracting Office directors, contracting officers' supervisors, and contracting officers. All Network Contracting Office directors and contracting officers' supervisors were unaware of contract performance deficiencies affecting veteran care identified by the OIG audit and expressed concern after the team informed them. Network Contracting Office directors and contracting officers' supervisors stated contracting officers need to maintain regular communication and conduct progress meetings with CORs to discuss and provide guidance related to the terms and conditions of the contracts and to review the CORs' quarterly evaluation reports.

Under the FAR, contracting officers are ultimately responsible for ensuring contractors meet the terms of the contract.[52] Thus, the oversight that contracting officers provide their CORs is important for protecting the government's interests and ensuring veterans obtain the needed services. However, the audit team found that in almost all cases, the contracting officers had not signed off on the quarterly evaluations, documented progress meetings, or provided feedback to CORs.[53]

For the four contracts with performance issues, CORs provided varying responses on what should be reported to contracting officers. Subsequently, none of the contracting officers were

[52] FAR 1.602-2 states, "Contracting officers are responsible for ensuring performance of all necessary actions for effective contracting, ensuring compliance with the terms of the contract, and safeguarding the interests of the United States in its contractual relationships."

[53] The handbook states that as part of ongoing monitoring activities, the COR and contracting officer must meet quarterly and document these meetings. Further, "Contracting Officer Representative SOP" in the VHA Procurement Manual states contracting officers must meet with CORs on at least a quarterly basis for all healthcare services contracts, discuss contractor performance, and document that the meeting took place. In addition, the SOP states contracting officers must meet with newly delegated CORs and review the terms and conditions of the contract and the required reports to be submitted. While the VHA Procurement Manual contains prescriptive language, VHA's Procurement and Logistics Office maintains that the manual is only a best practice and that it is not required to be followed.

aware of the issues the audit team identified, nor were they aware of some performance issues identified during prior annual inspections and quarterly evaluations. One COR for the San Francisco, California, Next Door Shelter contract disclosed that even though he tried to follow reporting requirements, he lacked clarification on what exactly needed to be reported. If contracting officers had consistently held and documented quarterly evaluation meetings and provided guidance to CORs, the contracting officer for the Next Door Shelter contract might have been able to help the COR understand his monitoring and reporting duties.

The general lapse in guidance and communication between the contracting officers and the CORs occurred because the Network Contracting Offices did not effectively monitor contracting officers to ensure they held required quarterly evaluation meetings with CORs to review the contract residences' performance. Contracting officers' supervisors disclosed to the audit team that their Network Contracting Offices faced high turnover, overwhelming workloads, and inadequate experience with healthcare contracts. Similarly, the contracting officers the audit team interviewed reported that high contracting office turnover, limited staff, overwhelming workloads, and inexperience with healthcare contracts also affected their ability to provide effective CRS contract oversight.

Furthermore, heavy workloads contributed to contracting officers forgetting to issue letters of delegation after they received email notification that CORs had been nominated by the medical facilities, even though the FAR requires contracting officers to designate a COR unless they choose to execute COR duties.[54] Existing controls, such as peer review teams used to identify administration deficiencies in the contracts, also did not detect the CRS contract files lacked the required copies of COR delegation letters or documentation of quarterly meetings with CORs.[55] Without letters of delegation, CRS social workers who acted as CORs might not be fully informed about their responsibilities, contract terms, or the extent of any limitations on their authority. Consequently, HCHV social workers monitored contractors and approved invoices without the proper authority and potentially put the government's resources at risk.

The Government Accountability Office also cited heavy contracting officer workload as a challenge when it added VA acquisition management to its High-Risk List in 2019, and referenced 21 prior recommendations that had not been implemented, including recommendations related to challenges in VA's acquisition management.[56] Furthermore, contracting officers' supervisors stated that their established review processes would not have identified contract administration issues such as the completion and documentation of quarterly evaluation meetings. As a result, Network Contracting Offices lacked control processes to make

[54] FAR 7.104(e).

[55] Network Contracting Offices generally have technical and legal teams to review contract files and identify missing contract documents.

[56] Government Accountability Office, *Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas,* GAO-19-393T, March 2019.

sure quarterly evaluation meetings were held and documented to periodically discuss and evaluate the contractors' performance and propose potential contractual remedies to performance deficiencies. Consistent documentation of contractor performance would have allowed HCHV program staff and contracting officers to make informed decisions when resoliciting contracts or deciding about exercising option years to extend contracts.

Contracting officers did not always ensure quality assurance surveillance plans were included in contracts, although the plans were required.[57] A quality assurance surveillance plan lays out the systematic method government employees will use to monitor the contractor's performance and, in short, describes what is going to be evaluated, the method of evaluation, and the performance standards the contractor needs to meet. The audit team found the San Francisco Next Door Shelter and Southern Arizona Old Pueblo Rapid Emergent Housing facilities with health and safety issues did not have quality assurance surveillance plans. The plans could have helped the CORs by identifying key contract requirements and specifying the government's method of inspection. Even when contracts included quality assurance surveillance plans, contracting officers did not always ensure CORs used the quality assurance surveillance plans to perform the quarterly evaluations. For example, the quality assurance surveillance plan for the Northport medical facility's United Veterans Beacon House contract stated the contractor was required to provide daily sign-in sheets to support invoices, and the COR should have reviewed the sign-in sheets at least each quarter. However, the COR did not require the contractor to maintain sign-in sheets.

Although the handbook, policy, and contracts require interdisciplinary inspections and quarterly evaluations by medical facility staff for all contractors, there are inherent weaknesses in this process if certain approaches are followed. The inspections and quarterly evaluations for Eastern Kansas were announced, which meant contractors could prepare for them. CORs and VA inspection teams have the authority to conduct unannounced inspections because HCHV contracts require records and other evidence for examination or audit to be available at all reasonable times, and state that inspections can be performed at any time. Despite this authority, CORs did not conduct unannounced inspections, nor were unannounced inspections encouraged in the handbook. The audit team concluded if occasional unannounced inspections and quarterly evaluations were conducted, issues related to case management documentation at the Eastern Kansas Rose Villa residence could have been identified, reported to the contracting officer, and corrected.

[57] FAR 37.601(b)(2) requires performance-based contracts for services to include "measurable performance standards … and the method of assessing contractor performance against performance standards." FAR 46.401(a) states quality assurance surveillance plans should be prepared in conjunction with the preparation of the statement of work and specify all work requiring surveillance and the method of surveillance. Also, VHA Handbook 1162.09 requires CORs to monitor contract performance by using a quality assurance surveillance plan.

Finally, CORs did not verify contractors appropriately billed VA when veterans were absent because the Homeless Program Office has not included any guidelines regarding payments for veteran absences in the handbook. Consequently, the audit team found CORs sometimes approved invoices when absences were not allowed by the contract.[58] The handbook could include guidance about paying for veteran absences.[59] Without clear guidance, billable absences could vary from contract to contract. The Homeless Program Office should consider updating the handbook and require CRS contracts and quality assurance surveillance plans to reflect these program requirements. The Homeless Program Office could then uniformly train CORs on billable absences using these revised handbook requirements.

Finding 2 Conclusion

VHA lacks assurance that VA medical facilities have adequate oversight of CRS programs to make sure they meet HCHV program and contract requirements and are good stewards of government resources. Medical facility annual inspection teams and CORs did not always identify deficiencies or ensure corrective action through annual inspections and quarterly evaluations for contractor residences' failure to maintain sanitary conditions, case management documentation, and safe medication storage practices. In addition, deficient contract administration practices by CORs at VA medical facilities led to medical facility staff performing contract monitoring functions without proper authority and approving invoices without obtaining supporting documentation.

These contract performance and administration problems in 13 of the 14 reviewed CRS contracts at the six reviewed medical facilities led to estimated improper payments of about $7.6 million, of which approximately $6 million was considered technically improper (lacking documentation or compliance with required processes).[60] In total, the audit team estimated that 107 of the 119 contracts belonging to VHA's largest CRS programs had contract performance and administration problems that resulted in an estimated $35.3 million in improper payments during the review period, of which approximately $21.6 million was technically improper.[61] Stronger monitoring of contractor performance and contract administration practices would provide VA

[58] Some contracts may allow contractors to bill VA for a limited number of days when veterans are absent.

[59] VA's Grant and Per Diem program, a similar transitional housing program for veterans, specifies when absences are billable. The program's policy, VHA Handbook 1162.01(1), *Grant and Per Diem (GPD) Program*, November 17, 2020, states that VA will not pay for any additional days of absence when a veteran has been absent for more than 72 hours.

[60] Of the $7.6 million in improper payments identified in this audit, $592,000 was due to inadequate contract monitoring and $7 million to inadequate contract administration.

[61] The remaining $13.7 million is an estimate of the total estimated improper payments and represents the possible monetary losses associated with CRS contract monitoring and administration deficiencies during the 12-month review period. However, the audit team did not consider the improper payments used to arrive at the estimate to be recoverable. A lack of documentation prevented the team from calculating the specific amounts due from each contractor, or the calculated collection amounts were so small a collection was not warranted.

with greater assurance that contractors are meeting the terms of their contracts and veterans are receiving the contractually required services, as well as reduce the risk of improper payments.

Recommendations 2–5

The OIG made the following recommendations to the VHA executive director for procurement:

2. Direct Network Contracting Offices to establish controls to verify contracting officers meet with contracting officer's representatives on at least a quarterly basis to evaluate contractor performance and document the meetings.
3. Direct Network Contracting Offices for all Contracted Residential Services contracts to ensure contracting officers include quality assurance surveillance plans and promptly issue letters of delegation to staff who have been nominated to be contracting officer's representatives.

The OIG made the following recommendations to the acting under secretary for health:

4. Update Veterans Health Administration Handbook 1162.09 to incorporate unannounced site visits to the extent possible during annual inspections and quarterly evaluations.
5. Update Veterans Health Administration Handbook 1162.09 to include guidance on paying for veteran absences and make certain these requirements are reflected in contracts and surveillance plans.

Management Comments

The acting under secretary for health concurred in principle with recommendations 2 and 3 and concurred with recommendations 4 and 5.[62]

To address recommendations 2 and 3, the VHA executive director of procurement will remind contracting officers of their responsibility to meet with CORs, evaluate the contractor's performance, document COR meetings, recommend meetings be held quarterly with CORs, include quality assurance surveillance plans, and promptly issue letters of delegation to CORs when appropriate.

To address recommendations 4 and 5, the acting under secretary for health agreed that Handbook 1162.09 should incorporate unannounced site visits during annual inspections and the quarterly evaluations to the extent possible and provide guidance on paying for veteran absences. These requirements would also be reflected in a new HCHV CRS directive, contracts, and surveillance plans. The acting under secretary for health stated that HCHV is working on

[62]The acting under secretary for health's comments and action plans included VHA's response to recommendations 2 and 3, which the OIG made to the VHA executive director for procurement.

replacing Handbook 1162.09 with a directive and these recommendations will be included in the final directive.

OIG Response

The acting under secretary for health's action plans for recommendations 2 and 3 state the VHA executive director for procurement will remind contracting officers of the aforementioned responsibilities. The action plans do not establish any additional controls, and therefore do not provide reasonable assurance, that the CRS contract oversight and administrative problems identified by the audit will not continue in ongoing contracts or recur in future contracts. The OIG will close recommendations 2 and 3 when VHA establishes additional controls to help prevent the recurrence of these problems.

Furthermore, the OIG acknowledges VHA's position in its general comments that the VHA Procurement Manual should not be viewed as policy. However, the importance of complying with the procurement manual was set forth in correspondence dated February 4, 2020, from VA contracting leaders to VHA's contracting staff. The correspondence states the guidance in the procurement manual is derived from and consistent with VA and federal regulations. In addition, the correspondence directs contracting staff to follow the procurement manual to the greatest extent practicable and states that deviations and exceptions require approval by the supervisory chain of command. However, the OIG did not find any deviations had been granted.

In its general comments, VHA's position is that the OIG inappropriately applied the term improper payments. VHA contends that a missing COR delegation letter does not make a payment technically improper if the payment is made to the right person for the right amount. The OIG disagrees with this position. Office of Management and Budget (OMB) Circular A-123, appendix C, states a payment can be technically improper even if it was made to the right recipient for the right amount, but the payment process failed to follow applicable statute and regulation. Further, FAR 32.905 states payments to the contractor will be based on a proper invoice and satisfactory contractor performance. As detailed in the report, when a COR is not delegated and when a contracting officer does not perform monitoring duties, VHA does not have an authorized official to evaluate satisfactory contractor performance. Because FAR 32.905 is an applicable regulation related to the payment process, the OIG determined payments were technically improper even though payments were made to the right recipients for the right amounts.

VHA's comments also discuss FAR 46.501 as it relates to acceptance of services, which the OIG raised in an earlier discussion of improper payments with VHA. While this topic was discussed prior to issuing the draft report, acceptance is not mentioned in this finding and it is not central to the OIG's position of technically improper payments. During that discussion, the OIG indicated that the contracting officers had not ensured the proper acceptance of services as required by

FAR 46.502 and that this made the related payments improper.[63] VHA contends that the OIG misinterpreted FAR 46.501 during this discussion and states that contracting officers are only responsible for obtaining evidence of acceptance. VHA does not acknowledge the OIG's main point, which was that FAR 46.501 states, "Acceptance constitutes acknowledgement that the supplies or services conform with applicable contract quality and quantity requirements … " and that acceptance could not be properly completed in accordance with FAR because an authorized official, either the contracting officer or a properly delegated COR, had not evaluated the contractors' performance.

Lastly, the OIG disagrees with VHA's position that contractor performance issues cannot result in an improper payment. VHA states since contractors bill VA under an all-inclusive rate and because the COR accepted these services, it is impossible to reduce the individual payment or per diem rate. This position is not consistent with the FAR. FAR 52.232-1 states the government shall pay the contractor upon the submission of an invoice for the agreed-upon price for services rendered, and FAR 52.246-4 states the government can reduce the contract price or require the contractor to perform as a remedy. Additionally, OMB A-123, appendix C, is clear that an improper payment exists if the government pays for a service that is not provided.

The OIG will monitor implementation of planned actions for recommendations 4 and 5 and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

[63] FAR 46.502 states that acceptance of supplies and services is the responsibility of the contracting officer.

Appendix A: Scope and Methodology

Scope

The OIG conducted its work from June 2019 through March 2021. It developed a sampling methodology that resulted in the review of six of 24 medical facilities that had over $1 million in CRS program expenditures during the 12-month period ending April 30, 2019. The six VA medical facilities selected for review are presented below in the order in which the OIG performed the site visits:

1. San Francisco VA Medical Center in California
2. Greater Los Angeles Healthcare System in California
3. Southern Arizona Health Care System in Tucson
4. New York Harbor Health Care System in New York City
5. Northport VA Medical Center in New York
6. Eastern Kansas Health Care System in Topeka

From these six VA medical facilities, the OIG reviewed a statistical sample of 14 HCHV CRS contracts from 12 providers. The OIG also reviewed medical facility HCHV case management records and payment documentation for 168 randomly selected veterans who entered the 14 contracted residences during the review period (May 1, 2018, through April 30, 2019). The team also conducted an additional review of these veterans for an eight-month follow-up period (May 1 through December 31, 2019).

Methodology

The OIG identified and reviewed applicable laws, regulations, VA policies, standard operating procedures, and guidelines related to the HCHV CRS program. The OIG also interviewed contractors to understand monitoring and oversight processes. Additional interviewees included Homeless Program Office officials; network homeless coordinators; and medical facility homeless program staff, contracting officers, and contractor staff. For the 168 randomly selected veterans, the audit team reviewed their electronic health records to determine whether medical facility homeless program staff completed assessments, treatment plans, monthly progress notes, and discharge plans as required by the handbook. In addition, the team reviewed invoices and supporting documentation for payments, such as sign-in sheets, to determine whether payments were accurate and consistent with contract terms.

The OIG conducted unannounced visits to 14 contractors' facilities to assess the general conditions of the homes, obtain veterans' files, and speak with veterans to determine if contractors complied with the terms and conditions of their contracts. In addition, the team

reviewed the Electronic Contract Management System and Electronic Contracting Officer's Representative System for contract-related documents, such as COR letters of delegation, quarterly evaluations, and communications to assess the adequacy of contract administration.

Fraud Assessment

The OIG assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The OIG exercised due diligence in staying alert to any fraud indicators. The audit team

- solicited the OIG's Office of Investigations for potential fraud cases involving CRS providers in the audit sample, and
- assessed CRS provider eligibility and veteran data for fraud indicators, such as payments made to ineligible transitional housing providers.

Data Reliability

The OIG relied on computer-processed data obtained from the Electronic Contract Management System and VHA's Homeless Operations Management and Evaluations System. To determine the reliability of data obtained from the Electronic Contract Management System, the OIG performed data analyses by comparing a list of homeless service providers through a query tool—the Electronic Contract Management System MicroStrategy Tool—to information in the Electronic Contract Management System and contract documents, such as contract numbers, award date, and homeless service providers' names, for the 14 statistically selected providers. Furthermore, the OIG assessed the appropriateness and reliability of the Homeless Operations Management and Evaluations System data, such as veterans' names and social security numbers, by cross-referencing the data against information in the Computerized Patient Record System. Lastly, the OIG assessed the reliability of data from the Financial Management System, such as invoice numbers, invoice dates, and payment amounts by matching invoices from the Invoice Payment Processing System. The OIG determined the data used were appropriate and sufficient for the audit's purposes.

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 audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Statistical Sampling Methodology

Approach

The audit team sampled VA medical facilities with CRS program expenditures of $1 million dollars or more during the 12-month period ending April 30, 2019.

The team determined whether

- VHA oversaw and monitored CRS programs to ensure they were operating effectively and helping veterans transition to permanent housing, and
- contracted services were provided in accordance with federal and VA acquisition regulations.

Population

The audit team selected the population based on the parameters of the audit objective and identified about $51.2 million in CRS payments made across 119 contracts by the 24 VA medical facilities with over $1 million in expenditures during the 12-month period ending April 30, 2019. The population of veterans was just over 6,800.

Sampling Design

The audit team used a multistage stratified sampling approach. In the first stage, it identified a stratified random sample of six VA medical facilities that had over $1 million in CRS expenditures. This sample included one certainty site and five sites selected from two strata—medical facilities with payments between $1 million and $2 million and medical facilities with payments over $2 million.[64] In the second stage, the team identified up to four contracts at each selected medical facility based on the total number of awarded CRS contracts at each facility.[65] In the third stage, a sample of 28 unique veterans was selected using simple random sampling. The sampling design resulted in the review of 14 contracts and 168 veterans from six medical facilities and allowed the audit team to project its findings from the sample to the population. Thus, the audit team projected the number of veterans who did not have adequate case management and who had related improper payments due to inadequate contract oversight.

Weights

The audit team calculated all estimates in this report using weighted sample data. Weights indicate how many items each sample unit represents in the population. Sampling weights are

[64] The OIG audit team selected a certainty site, the Greater Los Angeles Healthcare System, because the Los Angeles area has one of the highest concentrations of veterans experiencing homelessness in the country.

[65] Two of the six sites had more than four contracts; the team therefore limited its review to four contracts.

computed by taking the product of the inverse of the probabilities of selection at each stage of sampling. For example, the OIG calculated error rate estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights.

Projections and Margins of Error

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. The confidence level is the probability, the relative frequency of occurrence of an event, associated with a range of values that may contain or describe an unknown parameter. If the audit team repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

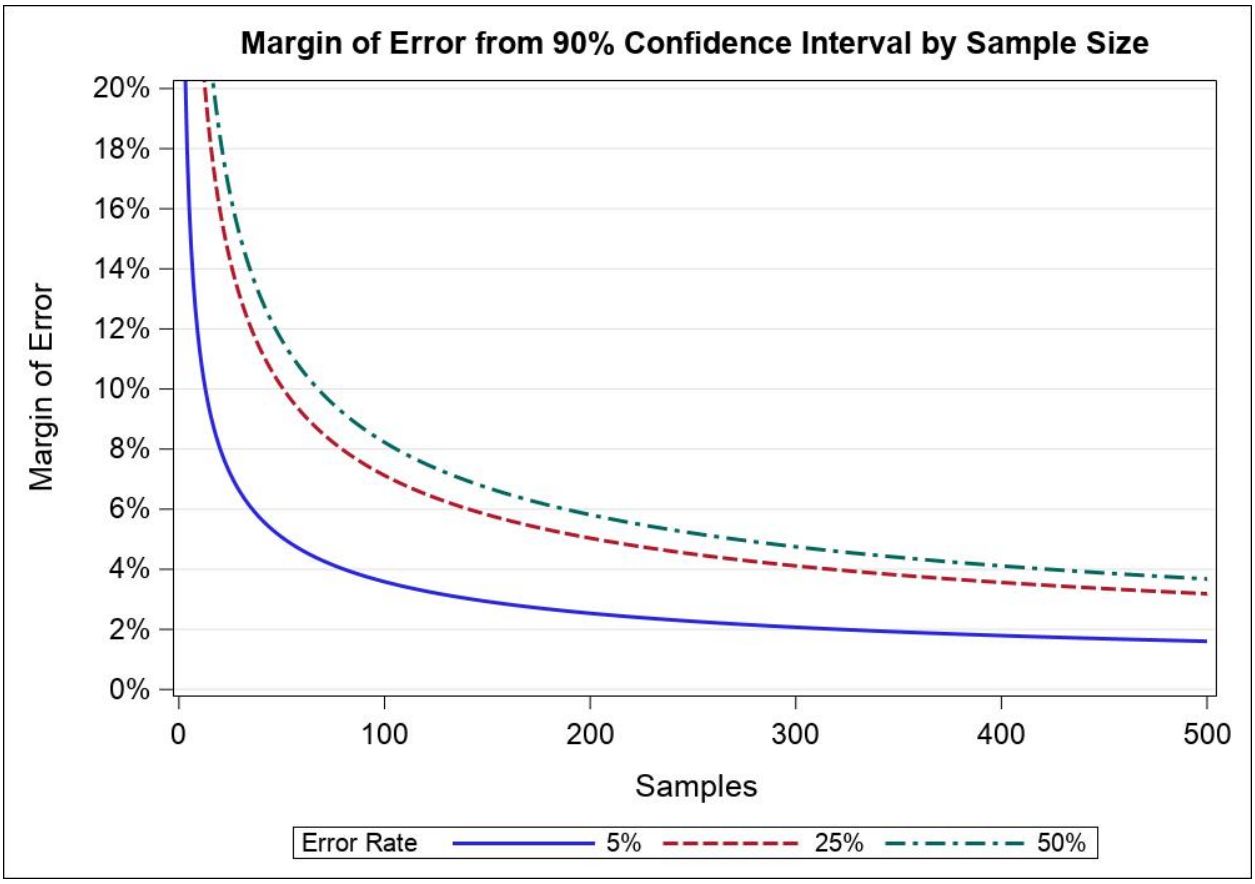

Figure B.1. *Effect of sample size on the margin of error.*
Source: VA OIG statistician's analysis.

Projections

Based on the sample results, the audit team estimated that large CRS programs (those expending more than $1 million) did not ensure adequate case management for about 3,400 of the 6,800 veterans (50 percent) during the review period. In addition, based on the $7.6 million in improper payments identified in contract monitoring and administration, the team estimated VA made about $35.3 million in improper payments to contractors during the review period, of which approximately $21.6 million was technically improper. Table B.1 on the next page summarizes the statistical projections.[66]

[66] The audit team identified improper payments of about $592,000 due to contractor monitoring deficiencies and $7 million (of which approximately $6 million was technically improper) due to contract administration deficiencies.

Table B.1. Statistical Projections Summary

Category	Estimate number	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Number of errors	Total sample size
Veterans who lacked case management documentation	3,400	360	3,000	3,800	86	168
Percent error of veterans who lacked case management documentation	50	5	44	55	86	168
Total improper payments due to inadequate contract monitoring and administration	$35,300,000	$18,700,000	$16,600,000	$51,200,000	13	14
Technically improper payments due to lack of COR delegation (inadequate contract administration)	$21,600,000	$13,500,000	$8,200,000	$35,100,000	8	14
Other improper payments due to inadequate contract monitoring and administration (excluding lack of COR delegation)	$13,700,000	$13,100,000	$658,000	$26,800,000	5	14

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations statistician.
Note: Based on 90 percent confidence interval. Figures are rounded for reporting purposes.

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

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
2–5	Stronger contractor monitoring and administration practices would (1) provide assurance that contract and program requirements are met and (2) reduce improper payments.		$35.3 million
	Total		**$35.3 million**

Note: The estimate of about $35.3 million in improper payments for one year is related to various contractor monitoring and administration deficiencies identified in 13 of 14 sampled contracts. The audit team found that CORs did not always ensure CRS contractors maintained required case management documentation to support billed services. Contracting officers did not always properly delegate authority to CORs so that they could properly authorize payments. Furthermore, CORs did not ensure contractors were paid the correct amount because they did not require the contractors to submit required supporting documentation with their invoices, ensure a contractor provided the services specified in the contract, or make sure contractors were only paid for allowable days or absences. The audit team did not consider the estimated improper payment amount recoverable because it included technical improper payments with nonmonetary losses and improper payments where the exact monetary loss could not be calculated due to insufficient documentation or the calculated amount was so minor a collection was not warranted.

Appendix D: Management Comments

Date: May 21, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services (VIEWS 05152398)

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

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report, Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services. The Veterans Health Administration (VHA) does not agree with the OIG's classification of the payments as improper. Details are discussed in the attached general comments. VHA also attaches its action plan to recommendations 1 through 5.

The OIG removed point of contact information prior to publication.

(Original signed by)

Richard A. Stone, M.D.

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION

Action Plan

OIG Draft Report: Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services

Date of Draft Report: April 19, 2021

Recommendations/ Actions	Status	Target Completion Date

The OIG made the following recommendations to the Acting Under Secretary for Health:

Recommendation 1: Establish control mechanisms at the Veterans Integrated Service Network and Contracted Residential Services program levels to ensure Contracted Residential Services staff at medical facilities comply with Handbook 1162.09 requirements for monitoring and documentation.

VHA Comments: Concur.

The Veterans Health Administration (VHA) agrees that control mechanisms at the Veterans Integrated Service Network (VISN) and Contracted Residential Services (CRS) program levels need to be established to ensure CRS staff at medical facilities comply with VHA Handbook 1162.09 requirements for monitoring and documentation.

The Healthcare for Homeless Veterans (HCHV) Program Office will develop an HCHV CRS oversight tool for Network Homeless Coordinators to utilize in monitoring medical facility compliance with Handbook 1162.09 requirements specific to monitoring and documentation. Written guidance and technical support for Network Homeless Coordinators on the use of the oversight tool and the subsequent reporting requirements will be developed and disseminated by the VHA Homeless Program Office.

Status: In progress Target Completion Date: October 31, 2021

Recommendation 2: Direct Network Contracting Offices to establish controls to verify contracting officers meet with contracting officer's representatives on at least a quarterly basis to evaluate contractor performance and document the meetings.

VHA Comments: Concur in principle.

VHA Executive Director of Procurement will remind contracting officers of their responsibility to (1) meet with contracting officer's representatives (COR); (2) evaluate the contractor's performance; (3) document COR meetings and; (4) recommend meetings be held quarterly with CORs.

Status: In progress Target Completion Date: October 31, 2021

Recommendation 3: Direct Network Contracting Offices for all Contracted Residential Services contracts to ensure contracting officers include quality assurance surveillance plans and promptly issue letters of delegation to staff who have been nominated to be contracting officer's representatives.

VHA Comments: Concur in principle.

VHA Executive Director of Procurement will remind contracting officers of their responsibility to include quality assurance surveillance plans and promptly issue letters of delegation to contracting officer's representatives when appropriate.

Status: In progress Target Completion Date: October 31, 2021

Recommendation 4: Update Veterans Health Administration Handbook 1162.09 to incorporate unannounced site visits to the extent possible during annual inspections and quarterly evaluations.

VHA Comments: Concur.

VHA agrees that Handbook 1162.09 should incorporate unannounced site visits to the extent possible during annual inspections and quarterly evaluations. HCHV is currently working to finalize a HCHV CRS Directive, which will replace Handbook 1162.09. The HCHV Program Office will ensure that this recommendation is included in the final draft of the directive.

Status: In progress Target Completion Date: October 31, 2021

Recommendation 5: Update Veterans Health Administration Handbook 1162.09 to include guidance on paying for veteran absences and make certain these requirements are reflected in contracts and surveillance plans.

VHA Comments: Concur.

VHA agrees that Handbook 1162.09 should incorporate guidance on paying for veteran absences and make certain these requirements are reflected in contracts and surveillance plans.

The HCHV National Office is currently working to finalize a HCHV CRS Directive, which will replace Handbook 1162.09. The HCHV Program Office will ensure that this recommendation is included in the final draft of the directive

Status: In progress Target Completion Date: October 31, 2021

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

Attachment

OIG Draft Report: Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services

1. VHA Procurement Manual (VHAPM) - As discussed at the statement of findings briefing, the OIG has inappropriately applied the VHAPM as regulatory instructions. The VHAPM are internal procedures, not policy, and should be viewed as additional guidance and strong practices.

2. Improper Payments (Contracting Officer's Representative Delegations (COR)) - As discussed at the statement of findings briefing, the OIG is inappropriately applying the term improper payment. A missing COR delegation letter does not make a payment technically improper. If the payments are being made to the right person for the right amount, then there are no improper payments because the contracting officer (CO) is still responsible for ensuring those payments are proper given that they never did a 'correct' delegation of their authority. The lack of a COR delegation letter would be an internal weakness with contractor surveillance, but it does not make it an improper payment. Also note, the VA Acquisition Regulation (VAAR) (VAAR 801.603-71 and VAAR 801.603-70) gives the CO authority to designate others and it does not have to be in writing. For example, most VA supply contracts/orders do not have delegated CORs and the CO does not approve the payment. The supply warehouse is responsible for receiving and approving the payment. The CO is responsible for ensuring the terms of the contract are met and receiving documentation that services were provided Federal Acquisition Regulation (FAR). If there is documentation from a government official that the services were received, then the payments are proper.

3. Improper Payments (Acceptance) - It appears the OIG is misinterpreting FAR 46.501. The CO is responsible for obtaining evidence of acceptance. The CO is not responsible to accept all supplies/services. This is supported by FAR 4.804-(1) and FAR 4.804 (a) – "Files for contracts using simplified acquisition methods should be considered closed when the contracting officer receives evidence of receipt of property and final payment, unless otherwise specified by agency regulations." and FAR 4.804 (b), " Files for firm-fixed-price contracts, other than those using simplified acquisition procedures, should be closed within 6 months after the date on which the contracting officer receives evidence of physical completion." These receipt procedures are also supported by the Government Accountability Office (GAO) internal control standards. If a CO awarded, accepted, and closed out all contracting actions, that would be a violation of the segregation of duties – see GAO-14-704G Federal Internal Control Standards.

4. Payment Process vs. Performance – As discussed at length with the OIG and in emails, the OIG appears to be confusing improper payments with contractor performance. Please note, VHA is not denying the contractor was not performing. VHA does not agree with the OIG's classifcation of the payments as improper. Please see further details below.

   The contract in question is for commercial services ordered off General Services Administration Multiple Award Schedule Schedules. As you will see from the below analysis, the contract clearly separates the payment vs. contractor performance and oversight as does the FAR. All performance-based contracts must have a Quality Assurance Surveillance Plan (QASP) and the QASP outlines the steps to take if a contractor is not performing along with FAR Clause 52.246-4 Inspection of Services Fixed Price.

Highlights from the contract:

- Page 5, Veterans are referred and approved for Health Care for Homeless Veterans (HCHV) care by the VA.
- Page 6. F., Method of Inspection and Acceptance: The COR will certify invoices for payment only for deliverables received and deemed acceptable…A QASP will be used by the COR in regards to stated performance standards.
- Page 6-7 also outlines 4 tasks that must be completed before referrals can be made or payments can be submitted.
- Page 18 D., Date of discharge of veteran approved by VA Liaison for billing purposes.
- Page 20, Per Diem, Billing and Payments: "The VA can only pay per Diem for eligible Veterans (i.e. Veterans whom VA refers to the contractor, or for whom VA authorizes the provision of services) as determined by the local VA medical center HCHV program." The section goes on to explain what is included in the Per Diem Rate. Per Diem Rate is the only deliverable in the contract.
- Page 22, Records and Reports
    - "As part of VA contract oversight, attention will be directed to the adequacy of Veterans' records..."
- QASP outline includes check of contractor documentation. COR required to complete a report.
- Page 50, item 7, outlines steps that are to be taken if the contractor is not performing.
- Clause 52.246-4 Inspection of Services Fixed Price also outlines the appropriate steps when contractor is not performing.

  (e) If any of the services do not conform with contract requirements, the Government may require the Contractor to perform the services again in conformity with contract requirements, at no increase in contract amount. When the defects in services cannot be corrected by reperformance, the Government may-

  (1) Require the Contractor to take necessary action to ensure that future performance conforms to contract requirements; and

  (2) Reduce the contract price to reflect the reduced value of the services performed.

  (f) If the Contractor fails to promptly perform the services again or to take the necessary action to ensure future performance in conformity with contract requirements, the Government may-

  (1) By contract or otherwise, perform the services and charge to the Contractor any cost incurred by the Government that is directly related to the performance of such service; or

  (2) Terminate the contract for default.

Also note the payment clause FAR 52.232-1: The Government shall pay the Contractor, upon the submission of proper invoices or vouchers, the prices stipulated in this contract for supplies

delivered and accepted or services rendered and accepted, less any deductions provided in this contract.

For example, if there is documentation that the COR accepted these services, which as defined in the contract the deliverable is the per diem rate (all-inclusive daily rate) for eligible Veterans as approved by the VA, then the invoice would be paid. The contract does not contain any deduction language for example if a Veteran only received part of the service. It is an all-inclusive rate. If the COR could only verify per diem for 70 and the contractor billed 80, then the invoice could be rejected. If the VA mistakenly paid the full amount of 80 then it would be considered an improper payment.

If the COR notes performance issues, then they follow the QASP and FAR clauses related to performance issues. For example, per page 50, the contractor must be notified in writing of the performance issues and the contractor must create a corrective action plan. The contractor per the FAR clause can also be given the opportunity to reperform the service. If the CO finds it necessary, the contract price could be reduced. Note the language in the clause, the CO can reduce the contract price, not an individual payment, i.e., reduce the per diem rate.

If the contract was non-commercial, then the procedures for FAR 32.10 Performance-Based Payments could have been used.

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

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