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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Inadequate Oversight of VHA's Home Oxygen Program

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Executive Summary

The Veterans Health Administration (VHA) uses vendors to provide oxygen services to veterans who need respiratory care in their homes. The Home Respiratory Care Program, otherwise known as the home oxygen program, has grown in recent years, with obligations of approximately $213 million in fiscal year 2019, about $257 million in fiscal year 2020, and requested obligations of around $278 million for fiscal year 2021.[1]

The program involves staff from various offices in VHA medical facilities. Clinical staff evaluate veterans' needs and provide prescriptions, contracting staff or contracting officer's representatives (CORs) monitor vendors' compliance and the quality of services, and contracting staff pay invoices. Because of the continued increase in spending on the home oxygen program, the VA Office of Inspector General (OIG) conducted this audit to determine whether VHA's oversight of the home oxygen program ensured (1) patients received reevaluation of their need for home oxygen and home visits were conducted as required, and (2) contractor performance was monitored and invoicing and payments were checked for accuracy.

What the Audit Found

The OIG found that (1) prescribing providers did not always reevaluate home oxygen patients timely and medical facility staff did not always conduct home visits for the required number of patients, and (2) contract monitoring by contracting officers and CORs was inadequate, caused by a lack of oversight and differing interpretations of guidance, while the payments were generally processed accurately. During the course of this audit, the team also found that VHA paid for services using expired contracts for two facilities.

Patient Reevaluations Were Not Completed on Time and Medical Facility Staff Did Not Always Conduct the Required Number of Home Visits

During the review period, prescribing providers should have reevaluated home oxygen patients no later than six months after patients were initially prescribed home oxygen, and then evaluated them annually thereafter to renew the prescription.[2] In August 2020, VHA updated its policy and shortened the requirement, mandating reevaluations within three months of the initial

[1] VA, FY 2021 Budget Submission, *Medical Programs and Information Technology Programs*, vol. 2, February 2020.

[2] VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

prescription, and removed the requirement for annual evaluations.[3] These patient reevaluations are a critical component of ensuring home oxygen patients receive oxygen at the necessary level.

The audit team determined that prescribing providers did not always reevaluate patients within the required time frame. The providers did not conduct an estimated 17,400 of 31,600 initial reevaluations (55 percent) within six months. The reevaluations were overdue because medical facility staff did not follow a uniform process to manage home oxygen consults, including addressing patient scheduling issues and applying required time frames. When medical facility staff do not reevaluate a patient as required, patients' health may suffer. Moreover, VA may continue to pay for home oxygen services without assurances that the patient needs them.

In addition to not always conducting timely reevaluations, staff were also not regularly conducting home visits as required. Home visits and reevaluations ensure that patients are safe and their needs are met. Home visits can also be used to assess the quality of the vendor service being provided. The audit team found that from July 1, 2018, through June 30, 2019, staff at 26 of 28 medical facilities did not conduct home visits for the required 10 percent of patients.[4] For the 26 facilities that did not meet the required percentage, some completed up to 8 percent, while others completed no home visits during this review period. Following the review period, VHA updated its policy in August 2020, and the audit team conducted a subsequent review of home visits from October 1 through December 31, 2020, to assess compliance with VHA's new policy.[5] The new directive allows the home visit reviews to be performed as home or telehealth visits and requires facilities to conduct a review of at least five patients in the home oxygen program per quarter. During the OIG review, the team determined that staff at 12 of 23 facilities did not conduct the required five home visits per quarter.[6]

Medical facility staff told the audit team that the home visits were not conducted during both review periods for various reasons, including patients not wanting staff in their homes due to COVID-19 in 2020 and staff confusion about the requirements. Furthering the confusion, neither VHA policy assigned responsibility to any individual or office to ensure home visit completion. If medical facility staff do not complete patient home visits, VHA lacks an essential component for ensuring patient safety and high-quality vendor service.

[3] VHA Directive 1173.13, *Home Oxygen Program*, August 5, 2020. This updated policy rescinded VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

[4] VHA Handbook 1173.13, November 1, 2000.

[5] VHA Directive 1173.13, August 5, 2020.

[6] The audit team reassessed nine of the 14 sampled contracts that were still active as of January 2021. This reduced the number of facilities covered by the contracts from 28 to 23.

Lack of Oversight and Inconsistent Interpretation of Guidance Led to Contract Monitoring Deficiencies

Contracting staff (contracting officers and CORs) maintain responsibility for monitoring and evaluating contracted services. To assess their performance, the team reviewed 14 home oxygen contracts for July 1, 2018, through June 30, 2019.[7] The contracts provided services through 28 medical facilities in 10 regional VHA networks, known as Veterans Integrated Service Networks (VISNs). The team also reassessed nine of the 14 contracts that were still active in January 2021. While the audit team determined that CORs generally ensured the completion of initial equipment setup and customer satisfaction surveys, the team identified deficiencies in other contract monitoring areas, including evaluating vendor performance and quality of services, as well as the proper designation of CORs.

Contracting Staff Did Not Complete Home Oxygen Vendor Performance Evaluation and Quality Assurance Reports

According to the VHA procurement manual, contracting officers or CORs should have completed and maintained at least four performance evaluations and quality assurance reports in the electronic contract management system (the official contract file) for the period reviewed.[8] If no COR is designated for a contract, the contracting officer is ultimately responsible for completing the evaluations and reports.

The audit team reviewed quality assurance surveillance reports, vendor reports, checklists, and meeting minutes to determine whether the performance evaluation and quality assurance report monitoring requirement was met as set forth in the procurement manual. For nine of 14 contracts reviewed, the contracting officer or COR did not complete vendor performance evaluations and did not complete quality assurance reports for 12 of 14 contracts. The team reassessed nine contracts that were still active in January 2021 and found that contracting officers and CORs still did not complete vendor performance evaluations and quality assurance reports for seven of the nine contracts.

The vendor performance evaluations and quality assurance reports are critical pieces of contract monitoring. They are used to determine the contractor's quality, ensure contractors are providing the agreed-upon services, and communicate that performance evaluation to the contracting officer. However, VHA did not establish oversight controls to ensure contracting officers or

[7] The 14 sampled contracts represented active home oxygen contracts awarded from October 1, 2015, through September 30, 2018.

[8] VHA Procurement Manual, part 801.603-70, sec. 6.1, "COR Meetings with the CO [Contracting Officer]," and sec. 6.2, "COR Reports," March 11, 2019, and part 801.1, "VHA Procurement Manual Overview." The VHA procurement manual provides procedures for procurement actions within VA and implements the Federal Acquisition Regulation (FAR), Veterans Affairs Acquisition Regulation, VA Acquisition Manual, and other statutory authorities.

CORs completed vendor performance evaluations and quality assurance reports, and then documented them in the contract file.

VHA's procurement leaders told the audit team they did not expect contracting staff to complete certain contract monitoring elements of the VHA procurement manual because the manual was not a regulatory document, but rather a compilation of best practices. However, VA contracting leaders communicated the importance of complying with the procurement manual in a February 2020 correspondence directed to VHA's contracting workforce that stated, "VHA Procurement staff are expected to follow the guidance contained in the VHAPM [VHA procurement manual] to the greatest extent practicable."[9] The correspondence went on to state the guidance in the procurement manual is derived from and consistent with VA and federal regulations. If VHA does not intend to use the procurement manual as policy or requirement, it needs to provide alternate guidance to procurement staff including standardized processes that staff can follow to achieve the elements included in the Federal Acquisition Regulation (FAR).

VHA Did Not Provide Oversight over Contracting Officer Designations

Contracting officers for all 14 contracts used a COR to perform actions such as certifying contractor performance and the availability of funding. However, in three cases the contracting officers did not properly designate a COR as required by the FAR, which states that the contracting officer should designate and authorize the COR in writing as early as practicable.[10] After the audit team brought this to the attention of the contracting officer or the COR in the three instances, two of the contracting officers resolved the issue by assigning CORs with a designation letter. The third contracting officer signed a designation letter but did not share it with the individual assigned as the COR to notify her, review her responsibilities, and get her signature as required. Without properly designating CORs, contracting officers put VHA at risk by allowing individuals to perform contracting actions without assuring they are properly trained, certified, or qualified to carry them out.

VHA regional procurement directors are responsible for maintaining adequate resources, personnel, and infrastructure within a regional procurement office, and providing support to local network contracting officers. However, based on discussions with VHA procurement and logistics staff, the audit team determined that VHA's regional procurement offices do not have a specific oversight role for the home oxygen program after contracts are awarded.

[9] VHA Office of Procurement, correspondence to VHA contracting workforce, "Expectations Regarding Veterans Health Administration (VHA) Contracting Officer's Utilization of the VHA Procurement Manual (VHAPM)," February 4, 2020.

[10] FAR 1.602-2.

Payments Were Generally Processed Accurately

To assess compliance with payment and invoice requirements, the audit team reviewed 120 payments that six medical facilities made for home oxygen services from July 1, 2018, through June 30, 2019. The team determined whether patients had active prescriptions, charges submitted by vendors were in line with requested services, and invoice amounts matched contracted rates. Overall, the team found that payments and invoices were generally accurate and that the errors found were nonmaterial.

VHA Paid for Services Using Expired Contracts for Two Facilities

During the audit, the team identified two home oxygen contracts that had expired in March 2019 but were still being used to place home oxygen service orders for patients of the Charlie Norwood VA Medical Center in Augusta, Georgia, and the Ralph H. Johnson VA Medical Center in Charleston, South Carolina, which are both covered by the same VISN. The contracting officer and a VISN prosthetic representative told the audit team in October 2019 that VHA planned to award a VISN-wide contract, which had gone through solicitation. In February 2020, the network contracting office director of contracting for the VISN confirmed that contracting specialists had paid for 13 orders after the contracts expired, totaling about $1.6 million from June 2019 through January 2020. However, as of January 2021, a VISN-wide contract had not been awarded and both facilities were using a month-to-month contract by purchase order with their respective vendors.

Another issue was that payments for home oxygen services at the Augusta medical facility were unauthorized commitments, since they were committed by a VISN prosthetic representative who was not authorized to obligate the government. While the team did not identify documentation supporting that the payments for the Charleston medical facility were also unauthorized commitments, VHA should perform a thorough review to determine if the payments were unauthorized and require ratification.

On April 1, 2021, the contracting office awarded contracts for each facility, with a period of performance ending on June 30, 2021, to address the gap in coverage. However, VHA will need to review the orders paid for both facilities before April 2021 and take appropriate actions.

What the OIG Recommended

The OIG made six recommendations to the under secretary for health. They were related to implementing guidance for managing home oxygen consults, clarifying reevaluation timelines, updating responsibilities for home visit oversight, and requiring network contracting office oversight of contracting officers to ensure completion of evaluation and quality monitoring elements and to properly designate CORs. The OIG also recommended clearly communicating the processes staff should use to achieve the contract monitoring requirements outlined in the FAR. Regarding the expired contracts, the OIG recommended reviewing the identified orders for

home oxygen services that were paid without an awarded contract and submitting a request for ratification for any unauthorized commitments to the VHA head of contracting activity.

Management Comments

The acting under secretary for health concurred with recommendations 1 through 3 and concurred in principle with recommendations 4 through 6. The acting under secretary for health stated that VHA considers recommendations 1 through 3 fully implemented and requested closure. Appendix C includes the full text of the acting under secretary for health's comments.

OIG Response

The action plans are responsive to the intent of the recommendations. Based on the information provided, the OIG considers recommendations 1 and 2 closed. The OIG will consider closing recommendation 3 when VHA provides additional evidence of the stated updated policy to assign oversight responsibility to ensure the required home or telehealth visits are completed. The OIG will also monitor the implementation of all planned actions relating to recommendations 4 through 6 and will close recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

COR	contracting officer's representatives
eCMS	electronic contract management system
FAR	Federal Acquisition Regulation
FY	fiscal year
NCO	network contracting office
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aids Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Home Respiratory Care Program in the Veterans Health Administration (VHA), generally referred to as the home oxygen program, assists veterans who need respiratory care. Oxygen is considered a medication and is used to help treat or prevent breathing disorders. Oxygen is distributed to patients by way of a concentrator, oxygen tanks or cylinders, or liquid oxygen. As a medication, home oxygen requires a prescription from a health care provider that indicates the needed levels of oxygen.

The program involves staff from various offices in VHA medical facilities. Clinical staff evaluate veterans' needs and provide prescriptions, contracting staff or contracting officer's representatives (CORs) monitor vendors' compliance and the quality of services, and contracting staff pay invoices.

The program was obligated approximately $213 million in fiscal year (FY) 2019 and $257 million in FY 2020, and VA requested obligations of about $278 million for FY 2021.[11] Because of the continued increase in spending on the home oxygen program, the VA Office of Inspector General (OIG) assessed VHA's oversight of several aspects of the home oxygen program to determine whether patients received reevaluations of their need for home oxygen and home visits were conducted as required, and whether contractor performance was monitored and invoicing and payments were checked for accuracy.

Program Background

VHA uses vendors to provide oxygen services to veterans who need respiratory care in their homes. Figure 1 provides an overview of the process, including VHA staff's responsibility to monitor the vendor's performance throughout.

[11] VA, FY 2021 Budget Submission, *Medical Programs and Information Technology Programs*, vol. 2, February 2020.

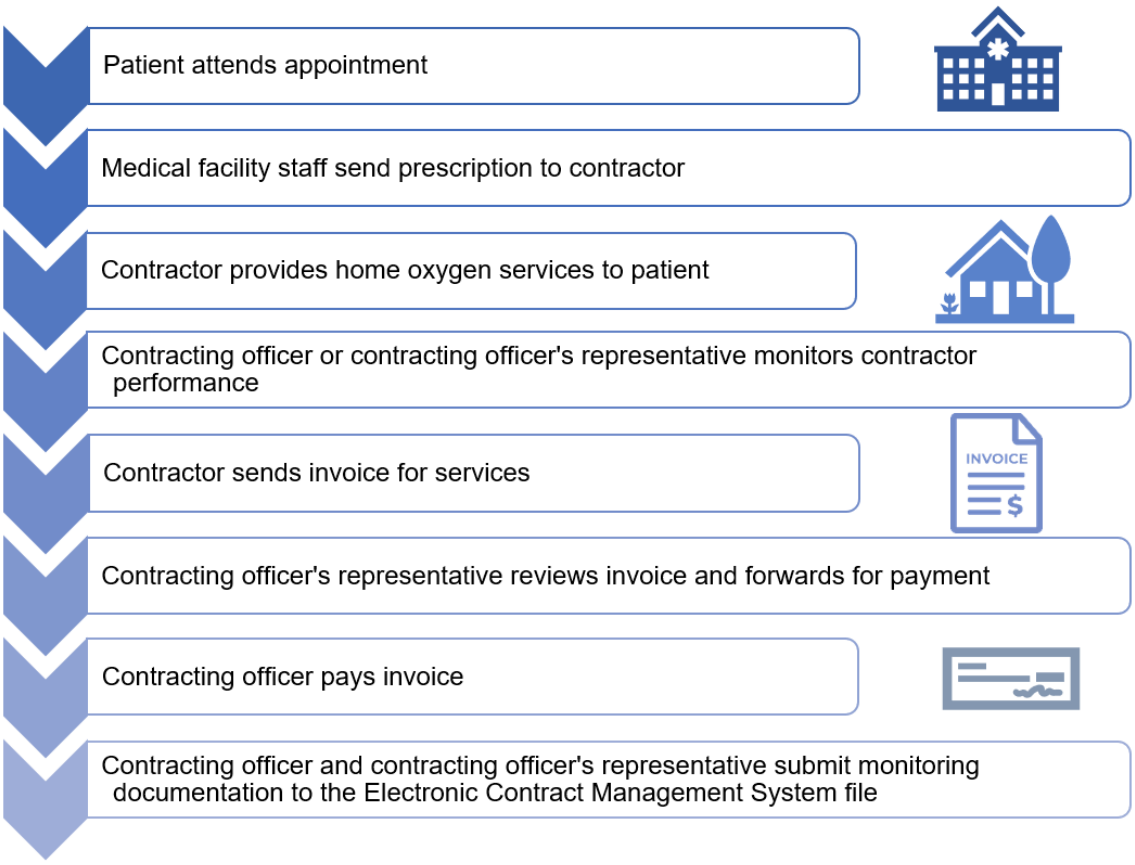

Figure 1. *Home oxygen program process.*
Source: OIG analysis of VHA policies.

Roles and responsibilities for administering this program include

- **VHA Prosthetic and Sensory Aids Service (PSAS)**—This program office is responsible for the national policies and programs for prosthetic and sensory aids, including the home oxygen program.
- **Contracting officers and contracting officer's representatives**—Contracting officers help ensure contracts meet requirements of law, regulations, or other applicable procedures and report to the network contracting offices (NCOs), which are aligned with Veterans Integrated Service Networks (VISNs). According to the FAR, "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."[12]

[12] FAR 1.602-2.

Contracting officers can designate a COR to assist in the technical monitoring or administration of a contract and in receiving and inspecting supplies and services.[13] The VHA procurement manual describes CORs as having an essential role in monitoring contract performance and ensuring VHA receives goods and services under the contract.[14] A VA handbook also states, "CORs are often the first to recognize when a program/project or contract is under-performing and are increasingly being asked to manage high-value, complex contracts."[15]

Prosthetics staff were generally designated as CORs for home oxygen contracts. The COR is required to maintain a file for each assigned contract.[16] VA policy mandates use of VA's electronic contract management system (eCMS) as the official file of record for documenting all procurement actions.[17]

- **Other VA medical facility staff**—According to VHA policy, the prosthetic service at VA medical facilities is responsible for administering the home oxygen program. This includes helping identify equipment requirements and develop a solicitation for the home oxygen contract, scheduling home visits, and monitoring contractual compliance.[18] Prosthetics staff are also responsible for payment functions, including purchasing or renting equipment, recording all transactions, and making payments for equipment and invoices associated with the home oxygen program.

  In conjunction with the prescribing provider, respiratory therapists at VA medical facilities are responsible for evaluating patients to determine the oxygen levels needed. Respiratory therapists are also responsible for educating patients on the use of home oxygen, including risks involved and harm-reduction measures.[19]

- **Other contracting staff**—Regional procurement offices provide support to NCOs. Regional procurement directors are responsible for maintaining adequate resources, personnel, and infrastructure in their region. NCOs provide local, regional, and national procurement support by overseeing contracting actions, such as ensuring compliance with eCMS requirements, and ensuring contracting officers comply with federal regulations. NCO directors are responsible for overseeing day-to-day operations of contracting,

[13] FAR 1.602-2 and 1.604; VA Acquisition Regulation 801.603-71.

[14] VHA Procurement Manual, part 801.603-70, sec. 3, "Responsibilities," March 11, 2019.

[15] VA Handbook 7403, *Federal Acquisition Certification for Contracting Officer's Representatives (FAC-COR) Program*, August 23, 2018.

[16] FAR 1.604.

[17] VA Procurement Policy Memorandum (2018-03), "Mandatory Usage of VA's Electronic Contract Management System (eCMS)," January 26, 2018.

[18] VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000. Any additional citations of the VHA Handbook reflect that they were in effect during the team's review. VHA updated this policy in August 2020.

[19] VHA Directive 1173.13, *Home Oxygen Program*, August 5, 2020.

purchasing, and procurement personnel. They are also responsible for ensuring compliance with the FAR and other regulations, directives, and policies. For home oxygen contracts, NCOs provide support to contracting officers.

This audit focused on

- reevaluating patients' continued need for home oxygen and conducting home visits (finding 1), and
- monitoring contractor performance and checking invoicing and payments for accuracy (finding 2).

In addition, this audit identified that VHA paid for services using expired contracts for two facilities, discussed in finding 3.

Reevaluating Patient Needs for Home Oxygen and Conducting Home Visits

VHA policy requires prescribing providers to reevaluate patients' needs for home oxygen. The policy that was in effect until August 2020 outlined the responsibility for prescribing providers to reevaluate newly prescribed home oxygen patients within six months, and annually thereafter, to ensure they still meet criteria for home oxygen therapy.[20] In August 2020, the policy was updated to require the initial reevaluation within three months and to eliminate the requirement for annual renewal evaluations.[21] The national program director of pulmonary, critical care, and sleep medicine stated the requirement for initial reevaluations changed because if the patient does not need long-term oxygen treatment, respiratory staff can typically determine that within the first 60 days.

Once a patient begins home oxygen therapy, VHA assesses patient use and the safety of these services through home visits. In November 2000, VHA policy required facilities to complete annual home visits for at least 10 percent of the patients on respiratory care. As of August 2020, VHA's policy required no fewer than five home oxygen patient reviews per quarter.[22] VHA staff can conduct these reviews through home visits or remotely via telehealth using a checklist that includes safety and patient education elements. The reviews are used to provide quality assurance of the service provided by the vendor.

[20] VHA Handbook 1173.13, November 1, 2000.

[21] VHA Directive 1173.13, August 5, 2020.

[22] The August 2020 policy update refers to both "home visits" and "reviews." Although the terms are different, the completion of the home visit or review fulfills the policy requirement. The audit team did not assess whether the change to five reviews per quarter was adequate; the team reviewed the number of visits that occurred to determine whether the facilities complied with policy.

Monitoring Contractor Performance and Checking Invoicing and Payments for Accuracy

Home oxygen contracts are awarded at a VISN or facility level. According to the PSAS national program director, the responsible contracting officer decides what type of contract the VISN or facility should use. Because vendors provide home oxygen services to patients, it is important that VHA staff monitor vendors' compliance with the contract.

The contracting officer or the designated COR maintains responsibility for monitoring and evaluating contracted services. The audit team assessed the following monitoring requirements:

- **Initial setup of home oxygen equipment**—The team reviewed home oxygen contracts that included requirements for the vendor to set up equipment in the patient's home.
- **Customer satisfaction surveys**—VHA policy requires the prosthetic service to monitor contractual compliance, including customer satisfaction surveys and patient interactions, and to document and maintain the results.[23] The survey can include information regarding patient satisfaction with the home oxygen program and services received from the vendor.
- **Vendor performance evaluations**—The VHA procurement manual requires CORs to provide a vendor performance evaluation quarterly, or more often if needed. The VHA procurement manual offers a template for the report that, when filled out by the contracting officer or COR, evaluates elements of the vendor's performance—including customer service, the contractor's services or products, and any other potential issues.
- **Quality assurance**—The FAR dictates that "government contract quality assurance shall be performed at such times…and places…as may be necessary to determine that the supplies or services conform to the contract requirements."[24] The VHA procurement manual requires that CORs provide a quality assurance report to the contracting officer during recurring meetings.
- **COR designation**—When a contracting officer designates a COR to help monitor or administer a contract, the FAR requires contracting officers to make this designation in writing and requires CORs to maintain a file for each assigned contract.[25] A COR must be trained and certified and must have the proper

[23] VHA Handbook 1173.13, November 1, 2000. VHA updated this policy in August 2020 requiring PSAS to take appropriate action in response to issues of contract compliance reported by the COR.

[24] FAR 46.401.

[25] FAR 1.602 and 1.604.

experience to complete contracting actions. COR responsibilities can include contract-specific reporting and documentation requirements.

The prosthetic service at VA medical facilities is also responsible for recording all transactions and expenditures for the home oxygen program using the Home Oxygen Module.[26] Prosthetics staff compare the amount on VA's request for services to the amount that vendors billed. The prosthetic service is also responsible for recording home oxygen use, purchasing new equipment and supplies, and paying vendor invoices following the preparation and review of payment documentation by contracting officers and approving officials.

[26] The Home Oxygen Module is a system within the Veterans Health Information System Technology and Architecture.

Results and Recommendations

Finding 1: Patient Reevaluations Were Not Timely and Home Visits Were Not Conducted for the Required Number of Patients

Because home oxygen requires a prescription, patient evaluations are crucial to ensuring veterans are receiving oxygen at the necessary level. The audit team determined that not all providers completed home oxygen patient reevaluations within required time frames, and medical facility staff generally did not conduct home visits for the required number of patients.

The audit showed that providers did not reevaluate an estimated 17,400 of 31,600 patients (55 percent) within six months of patients first receiving home oxygen.[27] Patients continued to receive oxygen services when their reevaluations were overdue because facility staff did not follow a uniform process to manage home oxygen consults, including scheduling. When medical facility staff do not reevaluate a patient as required, patient care could be negatively affected. Additionally, VA could continue to pay for home oxygen without assurances that the patient needs the services.

The audit team also observed that from July 1, 2018, through June 30, 2019, staff at 26 of 28 facilities reviewed did not conduct the required number of home visits to home oxygen patients. The audit team performed a subsequent review to assess compliance with VHA's new policy issued in 2020 and found that staff at 12 of 23 facilities reviewed did not conduct the required number of home visits from October 1 through December 31, 2020. Medical facility staff gave various reasons for not conducting home visits, including patients not wanting staff in their homes due to COVID-19, a facility not using telehealth visits even though these were allowed in lieu of in-person home visits, and respiratory staff confusion about the requirements. Although the August 2020 policy allowed the reviews to be performed as home or telehealth visits, it did not assign responsibility to any individual or office to ensure review completion. If the reviews or home visits are not completed, VHA will lack an essential component for ensuring patient safety and high-quality vendor service.

The following issues are discussed in finding 1:

- Initial reevaluations were not always completed within six months.
- Facility staff did not conduct the required number of patient home visits.

[27] VHA Handbook 1173.13 required reevaluations of initial home oxygen prescriptions to be conducted within six months and annually thereafter. In August 2020, VHA updated its policy and shortened the requirement to perform reevaluations to within three months. The audit team assessed the timeliness of initial reevaluations using the longer six-month standard in effect at the time the patients were prescribed home oxygen.

What the OIG Did

The audit team assessed a sample of 97 patients who received home oxygen equipment from October 2018 through May 2019. Using the sample, the team estimated about 31,600 patients overall were awaiting initial reevaluations of home oxygen. The team reviewed documentation in the sampled patients' electronic health records to determine if evaluations were completed within the required six months for initial reevaluations.

The audit team also reviewed documentation of home visits completed by staff at 28 medical facilities from July 1, 2018, through June 30, 2019, and a subsequent assessment of home visits conducted by staff at 23 medical facilities from October 1 through December 31, 2020.[28] The audit team communicated with facility prosthetics staff and reviewed various documents, such as logs and questionnaires, to determine the number of home visits each facility completed per quarter. Appendix A provides more information about the audit's scope and methodology.

Initial Reevaluations Were Not Always Completed Within Six Months

During the OIG's period of review, VHA Handbook 1173.13 required reevaluations documenting the continued need for home oxygen to occur within the first six months, and at least annually thereafter. The audit team found that an estimated 17,400 of 31,600 patients (55 percent) who received home oxygen did not receive an initial reevaluation within six months as required. Initial reevaluations were overdue an average of 122 days, with some 15,500 (49 percent) of the reevaluations overdue for 30 days or more.

When providers do not reevaluate a home oxygen patient after the initial prescription as required, the patient's health may suffer. Further, VA continues to pay for home oxygen services without assurances of patient need. The national program director for pulmonary, critical care, and sleep medicine stated that usually patients would either "get better" within the first few months of using oxygen or continue using oxygen for the rest of their life, underscoring the importance of this evaluation. According to the director, if patients no longer need oxygen but continue using it, there could be negative health consequences and safety risks.

Procedures Were Not Clear

Reevaluations did not occur on time because staff lacked guidance, including a process for managing scheduling problems. Instead, staff applied their own varying reevaluation timelines based on the type of home oxygen therapy patients received, leading to reevaluations later than six months.

[28] The audit team reassessed 23 facilities that were associated with nine of the 14 sampled contracts active as of January 2021. See Appendix A for more information.

No Process for Staff When Managing Reevaluation Scheduling Issues

VHA lacked standard guidance for staff to use when dealing with problems scheduling reevaluations of home oxygen, such as when patients do not attend reevaluations or request appointments past the required time frame for reevaluation.[29] VHA's 2020 home oxygen directive states that the respiratory therapist or home oxygen clinical coordinator is responsible for following up with the patient after an initial prescription.[30] Facility staff told the audit team some patients were medically or physically unable to attend appointments at the medical facility and others repeatedly canceled their appointments. One administrative officer at a facility stated that when a patient calls to cancel an appointment, the scheduler receiving the call may not always understand the risk to the patient or the requirement for the reevaluation appointment.

Facility staff also scheduled patients for reevaluations beyond six months when the patient requested an alternative date. For example, one facility respiratory therapist stated she rescheduled a patient two months after their reevaluation time frame because the patient preferred to have the appointment on the same date as a pulmonary function test. This resulted in a delay of about three months. A respiratory therapist at another facility reported applying a 12-month evaluation timeline based on the patient's medical determination, since it was unlikely the patient would come off oxygen.

According to home oxygen staff, patients still did not receive on-time reevaluations for a variety of reasons, including challenges in evaluating homebound patients, patients not attending scheduled appointments, and facility staff not following up with patients.[31] These patients continued to receive oxygen services without reevaluation of the need for home oxygen.

VHA has a policy regarding consult management that provides guidance for scheduling efforts required for outpatient appointments; however, the directive does not address the needs of the home oxygen program.[32] The consult directive states that after two documented attempts within 14 calendar days and no response from the patient, the scheduler is permitted to discontinue a consult without provider review and to stop scheduling efforts.[33] If the patient does not attend a scheduled appointment one or more times and does not respond to rescheduling efforts, the scheduler is also permitted to discontinue a consult, therefore ending home oxygen services.

[29] Staff involved in scheduling home oxygen reevaluations varied per facility. The audit team found that schedulers included prosthetics staff, respiratory therapists, and medical support assistants.

[30] VHA Directive 1173.13, August 5, 2020.

[31] Respiratory staff noted that some home oxygen patients are not mobile or are homebound and required a reevaluation at their home.

[32] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

[33] VHA Directive 1232(2) states that consults are discontinued when a consult is no longer wanted or needed. In the case of home oxygen, discontinuing a consult results in the patient no longer receiving oxygen services at home.

However, in the case of home oxygen, it may not be appropriate for an administrative scheduler to discontinue these consults without a clinical review because of the medical need for the oxygen service. Without further guidance, respiratory therapists and home oxygen staff are left to decide how to address these situations.

Example 1

In March 2019, a clinical technician sent a letter to a patient stating the facility had been unable to contact the patient by telephone. A facility nurse sent a second letter the next day and added a note in the home oxygen patient's medical record stating she attempted to contact the patient, but the number had been changed or disconnected or was not in service. Five days later, on April 1, 2019, a clinical note shows the patient called back about setting up equipment, but the consult was inappropriately discontinued later that day. Per policy, the consult should not have been discontinued since the patient contacted the facility within the allotted 14 days.[34] In January 2020, facility staff placed a new consult for home oxygen after the patient complained of having trouble breathing.

While some scheduling delays are unavoidable, medical facility staff need to have a standard process in place for handling patient requests that result in delayed reevaluations. Recommendation 1 addresses the need for VHA to implement comprehensive guidance for staff who schedule home oxygen consults, which will include procedures for working with patients who do not or are unable to attend scheduled reevaluations and for determining how and when to discontinue home oxygen services when appropriate.

Inconsistent Guidance for Scheduling Time Frame Led to Delays

VHA policy requires reevaluations of home oxygen patients within a specific time frame. Before August 2020, this time frame was six months after the initial prescription.[35] In August 2020, a new directive for the home oxygen program shortened the time frame to three months.[36] Neither policy included exceptions based on the type of home oxygen services prescribed.

However, some facility respiratory therapists scheduled reevaluations annually, rather than within six months, explaining they did so because the patients only received oxygen at night.[37] One respiratory therapist told the audit team that nocturnal oxygen prescriptions are good for one year from the day of setup or renewal. A respiratory therapist from a separate facility noted that

[34] VHA Directive 1232(2), August 24, 2016.

[35] VHA Handbook 1173.13, November 1, 2000.

[36] VHA Directive 1173.13, August 5, 2020.

[37] Patients on continuous oxygen use oxygen all day, while nocturnal oxygen is used only at night, often to help with low oxygen levels during sleep.

staff process nocturnal oxygen annually based on clinical practice recommendations. A VHA clinical practice recommendation document supports that position and notes that prescribing providers must evaluate nocturnal oxygen prescriptions annually, but the document does not indicate if a six-month reevaluation is also required.[38] Conversely, another facility followed the policy for all types of oxygen patients and scheduled reevaluations for patients within six months of the initial receipt of oxygen.[39]

The national program director of pulmonary, critical care, and sleep medicine stated that the August 2020 directive is only for patients using continuous oxygen and would not apply to other patients, such as those who were prescribed nocturnal oxygen only. However, the language in the directive did not clearly exclude nocturnal-oxygen-only patients or provide employees exceptions to change the scheduling time frames based on unique patient circumstances. If the August 2020 VHA directive only applies to patients receiving continuous oxygen, as noted by the director, VHA should ensure this limitation is clearly communicated and included in the directive.

Recommendation 2 calls on VHA to update guidance to outline any exceptions allowed to the scheduling time frame based on the type of home oxygen services prescribed.

Facility Staff Did Not Conduct the Required Number of Patient Home Visits

Medical facility staff could not provide evidence to the team demonstrating that VA facility staff performed the required number of home visits for home oxygen patients. The audit team conducted an initial review of home visits by staff from 28 facilities from July 1, 2018, through June 30, 2019, and an additional review of home visits following the August 2020 update to policy. The second review assessed whether 23 facilities conducted home visits from October 1 through December 31, 2020.[40]

Home Visits Fell Short During 2018 and 2019

Individuals from 26 of the initial 28 medical facilities did not provide documentation to support that facility staff conducted the required number of home visits during the review period. Staff at 15 of the 26 facilities completed some visits but still fell short of the requirement, while staff from the remaining 11 facilities did not provide documentation to support completing any home visits. During the period assessed, the handbook required the prosthetic service to schedule home

[38] VHA, Prosthetic Clinical Management Program Clinical Practice Recommendations, "Home use of supplemental oxygen," April 27, 2010.

[39] VHA Handbook 1173.13, November 1, 2000.

[40] The audit team reassessed nine of the 14 sampled contracts that were still active as of January 2021. This reduced the number of facilities reassessed for conducting home visits from 28 to 23. Appendix B provides more information.

visits for a minimum of 10 percent of home oxygen patients on a yearly basis. Because the number of home oxygen patients at each medical facility can differ, the number of required visits based on the 10 percent requirement would also differ. A home oxygen program manager stated that at the facility, staff first select a geographical area and then randomly select some patients who reside in or near that area to visit. The manager stated the geographical area of interest changes so that staff conduct home visits in different locations.

According to the handbook, the VA facility prosthetic service was required to administer the home oxygen program, to include scheduling home visits.[41] Table 1 shows the population of home oxygen patients served at each of the 17 facilities in the sample where staff conducted home visits and how many visits they completed.[42]

Table 1. Patient Home Visits Completed for 17 Medical Facilities

Facility	Population of home oxygen patients	Required number of visits	Visits completed	Percentage completed
1*	877	88	6	0.7
2	1,573	157	11	0.7
3	700	70	12	1.7
4	1,388	139	16	1.2
5	858	86	16	1.9
6	673	67	16	2.4
7	610	61	16	2.6
8	259	26	21	8.1
9	283	28	22	7.8
10	1,250	125	26	2.1
11*	250	25	26	10.4
12	856	86	27	3.2
13	419	42	35	8.4
14	921	92	38	4.1
15	849	85	47	5.5

[41] VHA Handbook 1173.13, November 1, 2000. This was the policy in place during the scope of this assessment.

[42] The 17 facilities include the two facilities that fulfilled the 10 percent requirement and the 15 facilities that completed some home visits.

Facility	Population of home oxygen patients	Required number of visits	Visits completed	Percentage completed
16	610	61	48	7.9
17	380	38	63	16.6

Source: OIG analysis of home oxygen contracts, Veterans Health Information System Technology and Architecture information, and home visit documentation provided by VHA staff.

**Home visits did not occur during the entire period of review because these contracts were not awarded until October 1, 2018. Therefore, home visits reviewed were not for the full one-year period.*

Prosthetics staff stated they followed varying guidance on home visits. Staff at two facilities stated they were told home visits were not required. One individual provided an email from a VISN prosthetic administrative officer with instructions that the medical facility did not have to conduct home visits unless a local policy is in place that states otherwise. Another individual provided documentation from a VISN prosthetics manager stating that although VHA Handbook 1173.13 is the governing reference, The Joint Commission does not require prosthetics staff to conduct home visits to monitor the contract.

During the period of review, there was conflicting guidance on the number of home visits required. VHA Directive 2001-057 and VHA Handbook 1173.13, established in 2001 and 2000 respectively, both outlined different requirements for the number of home visits each facility should conduct for home oxygen patients. The differences caused miscommunication from the VISN and inconsistency among facilities. PSAS did not provide clarifying guidance regarding the conflicting policy until July 2019, when the PSAS national director provided an update to VISN representatives via email that VHA Directive 2001-057 had expired and was archived. In this update, the director noted that VHA Handbook 1173.13 had also expired, but that VHA must follow guidance, including scheduling home visits with a minimum of 10 percent of patients annually.

Home Visits Were Still Not Being Conducted as Required by New Policy in 2020

The August 2020 VHA policy update changed standards, requiring medical facilities to conduct a review of at least five patients in the home oxygen program per quarter. However, staff at 12 of the 23 facilities assessed did not provide documentation to support that they completed the required number of home visits from October 1 through December 31, 2020. The 2020 directive allows the home visit reviews to be performed as home or telehealth visits. The policy also changed who is responsible for conducting the home visit reviews, stating they can be performed

by "a qualified individual" assigned by the medical facility chief of staff.[43] The previous handbook from 2000 had designated "multi-disciplinary teams consisting of clinicians and prosthetic representatives" to conduct home visits.

Staff at six of the medical facilities that did not perform the required number of home visits explained that this was due to the COVID-19 pandemic. Because of the pandemic, staff stated their facilities were understaffed or that veterans were not comfortable having VHA staff in their homes. Other individuals gave various reasons for not conducting the home visits, including confusion about what was required, or the retirement of the facility's home oxygen coordinator.

The audit team found that a lack of oversight led to the continued deficiency of home visits completed. The policy issued in August 2020 clearly defines the number of home visits that medical facilities must complete each quarter and outlines responsibility for the facility chief of staff to assign an individual to conduct these visits. However, VHA did not provide policy delegating oversight responsibility to any individual or establishing processes to verify that staff conducted the required number of visits and documented the results. Without this oversight process in place, VHA lacks assurance that the visits were completed and loses the opportunity to further ensure the overall safety of home oxygen patients and assess the quality of the vendor's service.

Recommendation 3 calls on VHA to assign oversight responsibility for verifying that home or telehealth visits occur as required.

Finding 1 Conclusion

Home oxygen patients' initial reevaluations were often not conducted within six months because medical center staff lacked guidance and faced scheduling challenges. First, VHA did not have clear procedures to address cancellations and missed appointments that are critical to assessing patients' ongoing need for home oxygen. Additionally, VHA policy did not clearly define or differentiate reevaluation requirements for staff to follow based on the type of home oxygen therapy patients were using, which resulted in home oxygen staff interpreting and implementing requirements inconsistently. Finally, medical facility staff generally did not complete the required number of home visits, and policy did not outline oversight responsibility to ensure they were conducted. Without timely patient reevaluations and home visit oversight, VHA will not be able to fully assess patient needs and safety nor the adequacy of home oxygen treatment.

[43] VHA Directive 1173.13, August 5, 2020. The individual may be a member of the Home Respiratory Care Team, a nurse, a primary care provider, or other individual as deemed appropriate.

Recommendations 1–3

The OIG recommended that the under secretary for health

1. Implement comprehensive guidance for staff who schedule home oxygen consults that includes processes for working with patients who do not or are unable to attend scheduled reevaluations, and for determining how and when to discontinue home oxygen services when appropriate;
2. Update guidance to include any exceptions to the scheduling time frame based on the type of home oxygen services patients are prescribed; and
3. Update policy to assign oversight responsibility for ensuring the number of home or telehealth visits outlined in guidance is conducted.

Management Comments

The acting under secretary for health concurred with recommendations 1 through 3, considered them fully implemented, and requested closure. In response to recommendations 1 and 2, the acting under secretary for health stated that VHA added guidance to its clinical indications associated with VHA Directive 1173.13 regarding follow-up evaluations and what to do when the patient misses or is unable to attend a scheduled reevaluation.

To address recommendation 3, the acting under secretary for health reported that VHA will update policy to assign oversight responsibility, and that VHA has updated its checklist to include the "Director/Chair of Home Respiratory Care Team" as the responsible person for oversight and there is a place for signature. VHA comments and action plans may be found in full in appendix C.

OIG Response

The corrective action plans are responsive to the intent of the recommendations. Based on the information provided, the OIG considers recommendations 1 and 2 closed. The OIG did not close recommendation 3 at this time because the evidence provided only supported oversight of a single instance of a home or telehealth visit. The OIG will consider closing the recommendation when VHA provides additional evidence that supports oversight responsibility is in place for ensuring that the required number of home or telehealth visits outlined in guidance are conducted. The OIG will monitor implementation of planned actions for recommendation 3 and ensure that VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issue identified.

Finding 2: Lack of Oversight and Inconsistent Interpretation of Guidance Led to Inadequate Contract Monitoring; Payments Were Generally Accurate

The audit team determined that contracting officers generally ensured home oxygen vendors delivered initial setup equipment and provided services, and CORs adequately surveyed home oxygen patients as required. However, VHA did not monitor all contractor performance elements included in the VHA procurement manual. The team found contracting officers or CORs did not evaluate vendor performance for nine of the 14 contracts assessed, or review the quality of services for 12 contracts. In addition, the team found that when contracting officers assigned CORs to represent them for a contract, some did not always properly designate CORs as required.

In January 2021, the audit team reassessed nine contracts that were still active and found that contracting officers for seven contracts still lacked vendor performance evaluations and seven did not complete quality assurance reports. This occurred because VHA had not implemented oversight processes to ensure that contracting officers and CORs completed the monitoring elements. Further, VHA procurement leaders told the audit team they did not expect contracting staff to complete certain elements of the VHA procurement manual because the manual was not a regulatory document, but instead a compilation of best practices. Without effective performance monitoring, VHA lacks assurance that the contractor is accomplishing the services agreed to and that home oxygen patients are receiving adequate services.

This finding addresses the following factors:

- Initial home oxygen equipment setup and surveys generally met requirements.
- VHA did not evaluate vendor performance and quality of services as outlined in the procurement manual.
- Contracting officers did not properly designate CORs for three contracts.
- Payments were generally processed accurately.

What the OIG Did

The audit team assessed 14 active, indefinite-delivery home oxygen contracts awarded from FY 2016 through FY 2018. The analysis included reviewing contract files to determine if VHA properly monitored contractor performance from July 1, 2018, to June 30, 2019.[44] The assessment covered five elements: vendors' initial setup of home oxygen equipment, customer

[44] The 14 contracts were valued at about $153 million and encompassed 28 VA medical facilities within 10 VISNs. The amount awarded for the 14 contracts included base and option years. Indefinite-delivery contracts have been awarded to one or more vendors to facilitate the delivery of supply and service orders.

satisfaction surveys, evaluation of vendor performance, quality assurance reporting, and COR designation. The audit team analyzed contract file documentation, including quality assurance surveillance reports, vendor reports, checklists, and meeting minutes, to determine whether the intent for the performance evaluation and quality assurance report monitoring was met.

Table 2 summarizes the audit team's analysis of the 14 contracts reviewed and compliance rates for each element. The table is further analyzed in the subsections that follow.

Table 2. Contract Monitoring Review Results

Contract	Initial equipment setup	Performance evaluation report	QA report	COR designation letter	Customer satisfaction survey
1	✓	✓	✓	✓	✓
2	✓	✓	✓	✓	✓
3	✓	x	x	✓	✓
4	✓	x	x	✓	✓
5	x	✓	x	✓	✓
6	✓	x	x	✓	✓
7	✓	x	x	✓	✓
8	✓	x	x	x	✓
9	✓	x	x	✓	✓
10	✓	x	x	x	✓
11	✓	x	x	✓	✓
12	✓	✓	x	✓	✓
13	✓	✓	x	✓	✓
14	✓	x	x	x	✓
Compliance Rate	93%	36%	14%	79%	100%

Source: OIG analysis of 14 contracts for the period of July 1, 2018, to June 30, 2019.

In January 2021, the audit team determined that nine of the selected 14 contracts were still active and reviewed documentation to assess compliance with performance evaluations and quality assurance report elements from July 1 to December 31, 2020.

Initial Home Oxygen Equipment Setup and Customer Surveys Generally Met Requirements

The audit team's review of 14 home oxygen contracts found that CORs generally ensured the completion of initial equipment setup and customer satisfaction surveys.

All 14 contracts reviewed required vendors to provide the initial setup of home oxygen equipment in a patient's home, usually within 24 hours of VA's request. The audit team found that 13 of 14 CORs provided documentation demonstrating that vendors met these requirements. The type of documentation that some CORs provided to support the equipment setup varied. For example, the COR for one contract trusted vendor-created quarterly reports to show the vendor met contract requirements, while the COR for another contract relied on other vendor-provided documentation such as delivery receipts and invoices. Nonetheless, the documentation generally supported that the equipment setup occurred.

CORs for all 14 contracts reviewed provided the results of customer satisfaction surveys to the audit team. VHA policy requires the prosthetic service to monitor contractual compliance using customer satisfaction surveys and to document and maintain the results.[45] These surveys give VHA an opportunity to collect information about the vendor from patients to ensure they were satisfied with the home oxygen program. The policy does not specify whether VHA or the contractor should conduct the surveys.

The audit team found that both the vendor- and VHA-conducted surveys were similar in terms of the information gathered and survey results. CORs for five contracts provided surveys conducted by the vendor only and reported to VHA during quarterly meetings; CORs for the other contracts provided VHA-conducted surveys. Both types of surveys inquired about timeliness, courtesy, and overall satisfaction. In addition, results from both types of surveys showed that patients were generally satisfied with vendor performance. Prosthetics staff stated that they reviewed and discussed survey results with the vendor during monthly or quarterly meetings. If issues were identified during those discussions, staff stated that the vendor made improvements or planned corrective actions.

VHA Did Not Evaluate Vendor Performance and Quality of Services as Outlined in the Procurement Manual

The audit team determined that for the period of July 1, 2018, to June 30, 2019, the contracting officer or COR did not complete performance evaluation reports for nine of 14 contracts and did not complete quality assurance reports for 12 of 14 contracts. According to the VHA procurement manual, contracting officers or CORs should have completed and maintained at

[45] VHA Handbook 1173.13, November 1, 2000. VHA updated this policy in August 2020, requiring PSAS take appropriate action in response to issues of contract compliance reported by the COR.

least four performance evaluations and quality assurance reports in eCMS (the official contract file) for the period reviewed.[46] However, the audit team found the contract files did not consistently include documentation showing the vendor performance and quality assurance monitoring elements were completed.

According to the FAR, "government contract quality assurance shall be performed at such times … and places … as may be necessary to determine that the supplies or services conform to the contract requirements."[47] The procurement manual states that the contracting officer "must meet with the COR" quarterly—at a minimum—to discuss contractor performance and adherence to contract requirements. The manual also states that the COR will provide the contracting officer with required reports, including a COR contractor performance evaluation and a quality assurance report, for discussion during that meeting.

In January 2021, the audit team reassessed nine of the 14 contracts that were still active and found performance evaluation and quality assurance reports were also not completed for the period of July 1, 2020, to December 31, 2020. During this review, the audit team determined that the contracting officer or COR did not complete the vendor performance evaluations and quality assurance reports for seven of nine active contracts.

These reports are a critical piece of contract monitoring because they are used to ensure the contractor is providing the services agreed on and furnishing patients with the correct items. The reports discussed in the manual are beneficial because they allow VHA staff to assess contractor performance multiple times a year before agreeing to continue business operations the next year. Not completing the reports hinders VHA's ability to adequately determine the contractor's performance and increases the risk of renewing contracts with vendors who are not sufficiently meeting VHA standards.

Lack of Oversight for Performance and Quality Reports

VHA lacked controls to ensure contracting officers or their designated CORs completed vendor performance evaluations and quality assurance reports and documented them in the contract file. According to the FAR, contracting officers are responsible for ensuring proper contract performance and compliance. Although a contracting officer has the authority to designate a COR as representation, the contracting officer is still ultimately responsible for effective contracting and proper monitoring of contract actions.

[46] VHA Procurement Manual, part 801.603 70, sec. 6.1, "COR Meetings with the CO [Contracting Officer]," and sec. 6.2, "COR Reports," March 11, 2019, and part 801.1, "VHA Procurement Manual Overview." The VHA procurement manual provides procedures for procurement actions within VHA and implements the FAR, Veterans Affairs Acquisition Regulation, VA Acquisition Manual, and other statutory authorities.

[47] FAR 46.401.

When the audit team asked why the reports were not completed, contracting officers gave varying responses:

- They assumed services were satisfactory if they received a bill from the medical facility.[48]
- They were not required to complete the reports.
- They did not know why CORs did not complete the reports.

The VHA procurement manual provides governance for procurement actions within VHA and requires a COR to provide reports during discussions of contractor performance with the contracting officer.[49] According to contracting staff, the reports help the COR monitor the contractor and communicate that performance to the contracting officer. When staff are not completing the reports, there is less assurance that the contract is monitored according to VHA's standards. VHA stakeholders should develop strategies that will ensure completion of performance evaluations and quality assurance, and that the results are communicated and documented.

Recommendation 4 addresses the need for VHA to provide oversight of contracting officers to ensure vendor performance evaluations and quality assurance reports are completed and documented in the electronic file.

Unclear Communication of Procurement Manual Requirements

VHA's procurement leaders told the audit team they did not expect contracting staff to complete certain contract monitoring elements of the VHA procurement manual because the manual was not a regulatory document, but a compilation of best practices. VHA leaders also stated that they considered the manual to be an internal procedures document and they did not require the elements to be completed by staff. Leaders also said they planned to update the entire manual.

Conversely, the VHA procurement manual states that it "provides procedures for procurement actions within VHA" and is "non-regulatory in nature," but also "provides uniform procedures for the internal operation of acquiring supplies and services within VHA." Further, it states that the manual is not considered a standalone document but "must be read in conformity with the FAR, and other regulatory documents."

February 2020 correspondence from three regional procurement executive directors to VHA's contracting workforce stated that "VHA Procurement staff are expected to follow the guidance contained in the VHAPM [VHA procurement manual] to the greatest extent practicable." The

[48] The vendor sends invoices to the medical facility. The invoices are certified and then forwarded to the contracting office for payment.

[49] VHA Procurement Manual, part 801.1, "VHA Procurement Manual Overview" and "COR Reports."

correspondence also included instructions for when deviations and exceptions to the guidance were made, including discussing the considerations with the "supervisory chain-of-command" and documenting the concurrence.[50] The correspondence states the guidance in the procurement manual is derived from and consistent with VA and federal regulations.

If VHA does not intend to use the procurement manual as policy or requirement, it needs to provide alternate direction to procurement staff including standardized processes that staff can follow to achieve the elements included in the FAR. Recommendation 5 addresses the need for VHA to clearly communicate processes or tools that staff should use to achieve the contract monitoring requirements in the FAR.

Contracting Officers Did Not Properly Designate CORs for Three Contracts

Contracting officers for all 14 contracts reviewed used a COR to perform contracting actions such as certifying satisfactory contractor performance and the availability of funding. However, contracting officers for three contracts did not properly designate the COR. The contracting officers violated the FAR requirement to designate and authorize the COR in writing as early as practicable. A COR must be trained, certified, and have the proper experience.[51] Further, the VHA procurement manual makes the contracting officer responsible for issuing the designation of authority memorandum to the COR and ensuring the COR signs the document. The memorandum outlines COR responsibilities and can include contract-specific reporting and documentation requirements.

After the audit team notified the contracting officer or the COR for each contract where the COR had not been designated, the contracting officers for two contracts resolved the issue by assigning CORs with a designation letter. For the third contract, the contracting officer signed a designation letter but did not provide the letter to the individual as notification of the COR assignment, nor did the COR review the responsibilities and sign the letter. In March 2021, the individual assigned as the COR confirmed that she had never received a letter from the contracting officer. When asked why the COR was not properly designated, the contracting officer stated the contract did not require a COR. However, the contracting officer used the individual to perform duties as the COR and was therefore responsible for designating the individual in writing, for issuing the memorandum to the COR, and for ensuring the COR signed the document.

[50] VHA Office of Procurement, correspondence to VHA contracting workforce, "Expectations Regarding Veterans Health Administration (VHA) Contracting Officer's Utilization of the VHA Procurement Manual (VHAPM)," February 4, 2020.

[51] FAR 1.602-2.

The VHA procurement manual states that the regional procurement office is responsible for confirming effective use of CORs. However, VHA guidance does not establish oversight responsibility for anyone to verify that contracting officers designated CORs in writing or that contracting actions were taken by authorized CORs representing the officer. Based on discussions with VHA procurement and logistics staff, the audit team determined that the regional procurement office does not have a specific oversight role for the home oxygen program after contracts are awarded.

In addition, performance standards for the NCO directors of contracting do not include steps to oversee the contracting officers to ensure they designate CORs in writing. Directors are generally tasked with monitoring procedures and guidelines. However, the standards do not assign direct responsibility to ensure contracting officers are performing in accordance with FAR and VHA procedures if they decide to designate a COR to represent them.

Without properly designating CORs, contracting officers put VHA at risk by allowing individuals to perform contracting actions without assuring they are properly trained, certified, or qualified to carry out those duties. In addition, without the required designation letter to specify and limit the COR's authority, a COR could illegally obligate government funds to a vendor or make undesired contract changes.

Recommendation 4 also calls on VHA to ensure contracting officers' compliance with requirements for designating CORs.

Payments Were Generally Processed Accurately

The audit team reviewed 120 payments that six medical facilities made to vendors to evaluate several aspects of home oxygen service payments that were made from July 1, 2018, through June 30, 2019. The review included (1) determining whether the patient who received the service had an active prescription before payment, (2) comparing the facility prosthetics staff request for services with the charges submitted by vendors, (3) comparing the vendor invoice charge with approved home oxygen contract rates, (4) assessing the separation of duties during the payment reconciliation process, and (5) determining if individuals who paid the purchase orders had appropriate warrants and credentials.[52]

The audit team identified one transaction for a patient without an active prescription, two facility prosthetics requests including costs for home oxygen items that did not match actual charges submitted by vendors, and four patient transactions on invoices that did not match contracted rates for services. The team did not identify material issues associated with the separation of

[52] Warrants are granted to contracting officers and outline authorized purchasing limits. VA Financial Policy vol. XVI, chap. 1B, October 2019, requires that contracting staff be certified at an appropriate level (i.e., warranted) to purchase goods and services that exceed the micropurchase threshold.

duties, and all purchase orders were paid by authorized individuals. Overall, the team determined these errors were not material and made no recommendations regarding payment processing.

Finding 2 Conclusion

Because of inadequate home oxygen contract monitoring, VHA cannot ensure that vendors adhered to contract requirements and that home oxygen patients received adequate and quality service. Contracting officers generally made sure that vendors completed the initial setup for home oxygen equipment as required and surveyed home oxygen patients appropriately; however, they did not adequately monitor contractor performance using vendor evaluations and quality assurance reports as set forth in the procurement manual and did not designate CORs properly. Without effective contract monitoring, VHA lacks assurance that the contractor is accomplishing services in line with the contract agreement and home oxygen patients receive quality care.

Recommendations 4–5

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

4. Require the network contracting offices to provide oversight so that (1) contracting officers ensure vendor performance evaluations and quality assurance reports are completed and documented in the electronic contract management system, and (2) contracting officers comply with requirements when designating contracting officer's representatives.
5. Clearly communicate processes or tools that staff should use to achieve the contract monitoring requirements outlined in the Federal Acquisition Regulation.

Management Comments

The acting under secretary for health concurred in principle with recommendations 4 and 5. To address both recommendations, the acting under secretary for health reported that the VHA executive director for procurement will form a work group with appropriate key stakeholders—including VHA procurement and logistics, and PSAS—to identify the root cause of insufficient home oxygen contract monitoring and deficient financial procedures, and then develop mitigation strategies. VHA plans to implement the recommendations by August 2022. VHA comments and action plans may be found in full in appendix C.

OIG Response

The corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions for the recommendations and ensure that VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Specifically, the OIG will monitor the development

of strategies that will ensure performance evaluations and quality assurance are completed and that the results are communicated and documented.

Finding 3: Two Facilities Obtained Home Oxygen Services with Expired Contracts

During this audit, the team determined that patients at two facilities continued receiving services for home oxygen without an established agreement between VA and the contractor. The Charlie Norwood VA Medical Center in Augusta, Georgia, and the Ralph H. Johnson VA Medical Center in Charleston, South Carolina, placed orders using expired contract numbers. The contracting specialists stated they did so because the procurement data system was showing the contracts as active, which has since been corrected.

In February 2020, the NCO director confirmed that VHA paid for 13 orders after the two contracts expired, totaling about $1.6 million from June 2019 through January 2020. VHA staff told the audit team that a VISN-wide contract has been in development since 2019 but has not been awarded.

What the OIG Did

The audit team reviewed orders paid for home oxygen services at both facilities after their respective contracts expired to determine how many orders were inappropriately placed using the expired contract numbers. For the Augusta medical facility, the team reviewed 22 orders paid from June 2019 through March 2021, totaling about $2.5 million. For the Charleston medical facility, the team reviewed 23 orders paid from June 2019 through April 2021, totaling nearly $3.2 million.

VHA Paid for Services Using Expired Contracts for Two Facilities

The two contracts that covered the VA medical centers in Augusta, Georgia, and Charleston, South Carolina, both in VISN 7, included four one-year option years. The option years could have extended the contracts through September 2020, but not all options were exercised and both contracts expired on March 31, 2019.[53]

The contracting officer and a VISN prosthetic representative told the audit team in October 2019 that they planned to award a VISN-wide contract that had gone through the solicitation process. A solicitation was posted and projected to be awarded in November 2019. However, the contracting officer stated that because of a protest before the solicitation, the NCO could not move forward without corrective action being taken.[54] As of January 2021, the contract still had

[53] The Augusta VA medical center contract was awarded in August 2016 and valued at about $3 million, while the Charleston VA medical center contract was awarded in September 2016 and valued at about $5 million.

[54] "Bid Protests & Appropriations Law," Government Accountability Office, accessed May 18, 2021, https://www.gao.gov/legal/bid-protests/faqs. A bid protest is a challenge to the award of a contract for the procurement of goods and services or a challenge to the terms of a federal contract. An interested party, generally a potential bidder for the contract, may file a protest.

not been awarded and, in the interim, both facilities established a month-to-month contract by purchase order with their respective vendors.[55]

After their respective contracts expired, both facilities continued to place orders using the expired contract numbers, which was inappropriate according to the NCO director of contracting.[56]

- For the Augusta medical facility, eight orders totaling about $888,000 were issued using the expired contract number.
- For the Charleston medical facility, five orders totaling about $679,000 were issued using the expired contract number.

The FAR requires that orders be issued within the contract's period of performance.[57] Because the orders were issued outside the period of performance, absent a statutory exception to the fair opportunity process, these orders were placed in violation of the FAR and Competition in Contracting Act of 1984.[58] These violations could have subjected VA to potential bid protests.

Moreover, the eight orders paid for home oxygen services at the Augusta medical facility were unauthorized commitments, as they were committed by an individual who was not authorized to obligate the government. The audit team identified email documentation in the contract file from the contractor to the contracting officer, as well as other VA medical center and VISN staff, noting that the contract had expired and asking for an update on an extension. The contracting officer acknowledged the contract expired. She stated that there was no extension available for the contract and the medical facility service lines would work to put a new contract in place or identify options to continue services and provide an update to the contractor. The contractor also received direction from a contract specialist to stop servicing the veterans if the contract expired. However, a VISN 7 prosthetic representative communicated to the contractor that all contracts "have a transition period" and no one had "given directions to just stop servicing" veterans. The prosthetic representative was not authorized to obligate funds to a vendor.[59] Based on a review of the eight invoices paid using the contract number after the contract expired and this communication, the audit team concluded that the actions completed by the VISN prosthetic representative reflected an unauthorized commitment because she lacked contracting authority.

Although similar communication was absent from the file for the Charleston medical facility's expired contract, the payments and activity were similar to what was identified for the Augusta medical center. VHA should review the orders paid using the expired contract for the Charleston

[55] The month-to-month contracts were issued in accordance with part 6 of the FAR, *Competition Requirements*.
[56] NCOs share the same identifying number as the VISN they cover.
[57] FAR 16.505.
[58] 41 U.S.C. § 3301.
[59] FAR 1.602-3.

medical facility to determine if any payments would also be considered unauthorized commitments and require ratification. A ratification after the payment is not prohibited by the FAR, and is appropriate for this issue because it would be beneficial from a program perspective.

Recommendation 6 calls on VHA to review the orders that were paid for home oxygen services for the Augusta and Charleston medical facilities without an awarded contract and submit a request for ratification to the VHA head of contracting activity for any unauthorized commitments.

On April 1, 2021, the contracting office awarded contracts for each facility to address the gap in coverage, with a period of performance ending on June 30, 2021. However, VHA will need to review the purchase orders paid before April 2021 and determine the appropriate actions to take. VHA should also ensure the interim contracts continue until the VISN-wide contract is established.

Finding 3 Conclusion

Two home oxygen contracts that had expired in March 2019 were still being used to place home oxygen service orders for patients of the VA medical facilities in Augusta, Georgia, and Charleston, South Carolina, in VISN 7. Contracting officers did not conform their contracting actions to the FAR. Interim contracts are still needed to avoid further violations and unauthorized commitments until a VISN-wide contract is established.

Recommendation 6

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

6. Ensure facilities in Veterans Integrated Service Network 7 review orders that were paid for home oxygen services without an awarded contract and submit a request for ratification to the head of the contracting activity for any unauthorized commitments.

Management Comments

The acting under secretary for health concurred in principle with recommendation 6. The acting under secretary reported that VHA will ensure facilities review the orders in question and consult with the Office of General Counsel and Network Contracting Office 7 to determine if a request for ratification to the head of the contracting activity is required, and if so, have the facilities submit the required documentation. VHA plans to complete the recommendation by January 2022. VHA comments and action plans may be found in full in appendix C.

OIG Response

The action plan is responsive to the recommendation. The OIG reminds the acting under secretary that, in a 2013 memorandum to the deputy assistant secretary, the Office of General

Counsel recommended a ratification even if payment has already been made and it is not legally required "in order to properly document the action."[60]

The OIG will monitor implementation of the planned actions and ensure that VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

[60] VA Office of General Counsel memorandum, *Unauthorized Commitment and Ratification*, December 17, 2013.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from June 2019 through September 2021.[61] The team assessed documentation and data related to home oxygen patient reevaluations and home visits, contract monitoring for services provided to patients, and payment accuracy.

To determine if clinicians reevaluated patients timely, the team reviewed consult information in the National Prosthetic Patient Database for patients served by 140 medical facilities from October 1, 2017, through May 31, 2019.

To identify whether home visits occurred timely, the team requested documentation of home visits that occurred from July 1, 2018, through June 30, 2019. The team reassessed 23 facilities that were associated with nine of the 14 active contracts as of January 2021.

To review contract monitoring performance, the team obtained a universe of active home oxygen contracts that were awarded in fiscal years 2016, 2017, and 2018.[62] The team reviewed 14 home oxygen contracts that service 28 facilities within 10 VISNs as shown below.

Table A.1. Home Oxygen Contracts Reviewed

Contract number	VISN	Number of facilities covered by contract
36C24218D0064	2	5
VA25816D0142	22	4
VA25816D0143	17	3
VA24816D0040	8	1
36C24418D0066	4	4
VA25116D0047	10, 12	3
VA24516D0001	5	1
VA24817D0099	8	1
36C24418D0067	4	1

[61] The audit was paused for several months to conduct oversight related to the COVID-19 pandemic.

[62] Indefinite-delivery contracts have been awarded to one or more vendors to facilitate the delivery of supply and service orders.

Contract number	VISN	Number of facilities covered by contract
36C24818D0159	8	1
VA24817D0037	8	1
VA24716D0167	7	1
VA24716D0168	7	1
36C26018D0084	20	1

Source: VA OIG's analysis of contract information in VA's eCMS.

To assess home oxygen invoice and payment accuracy, the team reviewed purchase orders and associated payment information for the period of July 1, 2018, to June 30, 2019, covering the following facilities: Charlie Norwood VA Medical Center, Augusta, Georgia; Coatesville VA Medical Center, Coatesville, Pennsylvania; Lebanon VA Medical Center, Lebanon, Pennsylvania; Northern Arizona VA Health Care System, Prescott, Arizona; Ralph H. Johnson VA Medical Center, Charleston, South Carolina; and West Texas VA Health Care System, Big Spring, Texas. Appendix B provides more information on statistical sampling.

Methodology

To assess VHA's oversight of consult management, home visits, contract monitoring, and payment processing for the home oxygen program, the audit team interviewed PSAS and Procurement and Logistics Office staff to determine roles and responsibilities. The team also interviewed respiratory and pulmonary staff at medical facilities to gain an understanding of the consult process. In addition, the team reviewed applicable laws, regulations, VA policies, and guidelines related to the home oxygen program.

Patient Evaluations

The team reviewed (1) home oxygen patient medical records in VA's Compensation and Pension Records Interchange system to assess reevaluation timeframes and patient concerns and (2) notes and questionnaires to determine if facilities evaluated patient satisfaction with the home oxygen vendor during patient evaluations and recorded the results. The team determined that facilities generally did not use consults, medical record notes, or questionnaires to document patient concerns, although they were not required to do so.

Home Visits

The team reviewed eCMS records as well as documentation of home visits that the CORs provided. The team also determined the number of patients covered under each contract to assess

the required number of home visits per guidance by reviewing contract information. For contracts that did not list a number of patients per facility, the team used the information provided by the CORs. The number of home visits required by guidance was then compared to the reported number of home visits to determine if the requirement was met.

Contract Monitoring

The team evaluated indicators for vendor performance monitoring, including initial home oxygen setup, performance evaluations, quality assurance reports, COR designation, and customer satisfaction. To accomplish this, the team reviewed documentation in the contract files stored in eCMS. Specifically, the team reviewed contract documents including COR designation letters, performance evaluations, quality reports, and meeting minutes supporting contracting actions from July 1, 2018, through June 30, 2019. Any necessary documents not found in eCMS were requested from the responsible contracting officers or CORs.

Payment Reviews

To evaluate the accuracy of home oxygen payment reconciliations, the team assessed information from the Financial Management System; patient data from the Veterans Health Information System and Technology Architecture, including prescription reports; and other supporting documentation, such as purchase orders and invoices.

The audit team used this information to determine if

- patients had an active prescription at the time of home oxygen services,
- line items matched the charges billed by vendor and contract price,
- purchase orders included the appropriate budget object code,[63]
- purchase orders were paid by a contracting specialist or contracting officer with proper authority, and
- evidence of separation of duties was present during the payment reconciliation process.

Internal Controls

The team assessed internal controls over contract performance, payments, home visits, and consult management. The team reviewed the five internal control components—control environment, risk assessment, control activities, information and communication, and

[63] VA Financial Policy, vol. II, chap. 6, July 2018. VA uses Form 1358 as an obligation control document. VA Financial Policy, vol. XIII, chap. 2, November 2019. Budget object codes correspond to financial obligations according to the nature of the services or items purchased by the federal government.

monitoring.[64] The team assessed the design, implementation, and operating effectiveness of these internal controls as necessary to address the audit objective and identified deficiencies with the components outlined below:

- **Control environment and control activities:** VHA did not ensure that the required number of home visits were conducted, or that contracting officers and CORs completed vendor performance and quality assurance reports as noted in the procurement manual. The audit team also found that some CORs were not properly designated, and that VA paid for home oxygen services using expired contracts.
- **Information and communication:** The team found VHA lacked guidance or did not clearly communicate requirements for contract monitoring elements, such as vendor performance evaluations and quality assurance reports, and staff had differing interpretations of guidance regarding consult evaluation time frames.
- **Monitoring:** VHA did not establish oversight processes for NCO directors to assess contracting officer compliance with contract monitoring elements or COR designation. In addition, there was no monitoring in place to assess the timeliness of consult evaluations for home oxygen patients.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators by conducting documentation reviews and interviews with medical facility staff.

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

Data Reliability

The team performed testing to ensure the reliability of computer-processed data from eCMS and the National Prosthetic Patient Database. To ensure the accuracy of the sample of contracts, the team reviewed home oxygen contracts in eCMS and verified that the contracts were for home oxygen, indefinite-delivery, and that the award date was within the team's scope. To determine if National Prosthetic Patient Database information was reliable, the team compared patient records from the patient database with veterans' VA electronic health records. Based on these reliability assessments, the team concluded that data used were appropriate and sufficient for purposes of the audit.

[64] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

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

Appendix B: Statistical Sampling Methodology

To accomplish the objective, the audit team used statistical sampling to assess and quantify the payment accuracy and patient reevaluations for the home oxygen program. The team reviewed samples extracted from VA's National Prosthetic Patient Database, eCMS, and the Financial Management System.

Population

The review population included 14 active home oxygen contracts awarded from October 1, 2015, through September 30, 2018, valued at about $153 million. Table B.1 lists all the contracts included in the population.

Table B.1. Contract Sample

Vendor contract	Contract value ($)
1. 36C24218D0064	23,623,319.00
2. 36C26018D0084	3,314,582.57
3. 36C24418D0067	12,402,990.00
4. VA248-17-D-0099	6,764,814.08
5. VA245-16-D-0001	3,704,683.56
6. VA247-16-D-0167	3,053,230.00
7. VA258-16-D-0143	15,324,435.74
8. VA258-16-D-0142	38,063,528.70
9. 36C24418D0066	17,935,560.00
10. VA248-16-D-0040	2,637,793.56
11. VA251-16-D-0047	13,523,238.00
12. 36C24818D0159	6,170,184.14
13. VA247-16-D-0168	5,142,282.00
14. VA248-17-D-0037	1,429,275.00
Total	**153,089,916.35**

Source: Statistical analysis performed in consultation with an OIG statistician.

The payment accuracy review population consisted of 119 purchase orders and 249,036 National Prosthetic Patient Database payments associated with eight contracts and covered 17 medical facilities. The purchase orders were for services rendered from July 1, 2018, through June 30, 2019, and totaled about $15.7 million.

The consult review population included 221,831 home oxygen patients selected based on identified home oxygen deliveries for services provided from October 1, 2017, through May 31, 2019. The population included patients served by 140 medical facilities.

Sampling Design

The audit team selected a statistical sample of payment records from a population of National Prosthetic Patient Database home oxygen orders using a two-stage sample design. In stage 1, 10 sites were statistically selected in proportion to size based on the average cost per patient measure at each site. In stage 2, the audit team reviewed 20 patient transaction samples from six of the randomly selected sites for a total of 120 samples.

For the consult management review, the OIG randomly selected consults by stratifying the population into three categories based on the number of home oxygen patients per facility based on National Prosthetic Patient Database data.

Weights

The estimates in this report were calculated using weighted sample data. Samples were weighted to represent the population from which they were drawn. The team used the weights to compute estimates. For example, the team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights for all sample records. For the two-stage design, the sampling weight for each payment is the product of the following:

- The stage 1 selection factor for each of the six selected sites of the 17 total sites selected in proportion to the average cost per patient measure, and
- The stage 2 selection factor was based on National Prosthetic Patient Database orders for the six sites identified in stage 1 and the first location associated with the unique patient identifier. Within the weighted sample 120 patients were selected for review.

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. 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, and table B.2 shows the summary of projections for consult evaluations.

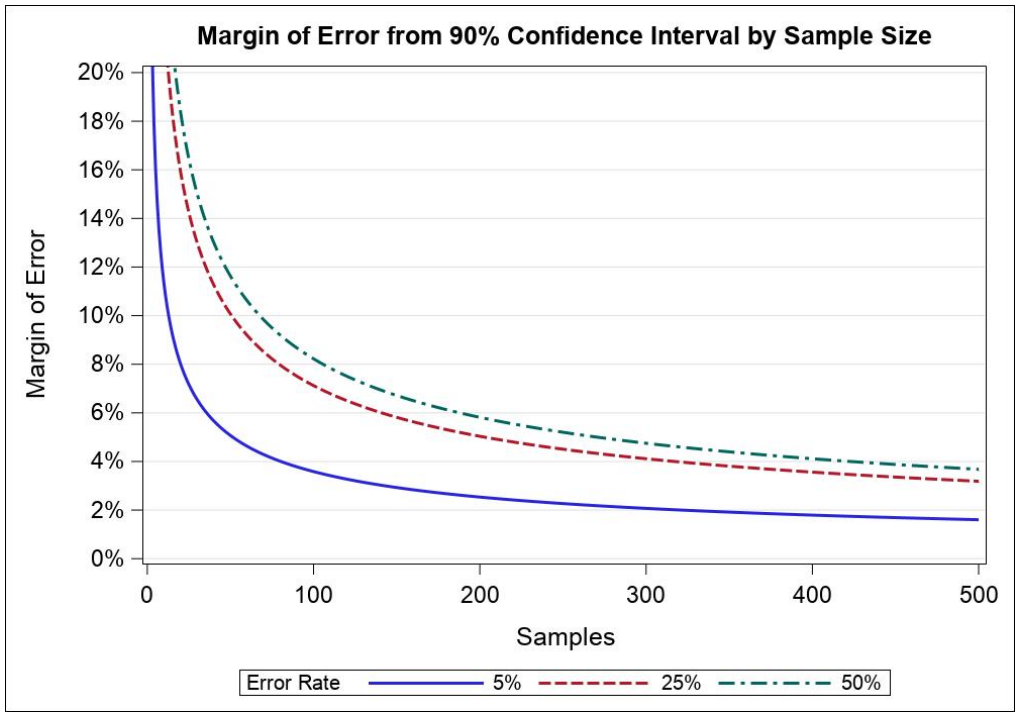

Figure B.1. *Effect of sample size on margin of error.*
Source: VA OIG statistician's analysis.

Table B.2. Statistical Projections Summary for Consult Review

Type of consult	Estimate (percent)	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Numbers in sample
Initial patients	31,557 (19)	11,245 (7)	20,311 (12)	42,802 (25)	18
Overdue initial patient reevaluations	17,361 (55)	6,489 (21)	10,872 (34)	23,851 (76)	10
Initial patient reevaluations—overdue more than 30 days	15,550 (49)	6,005 (19)	9,545 (30)	21,555 (68)	9
Initial patient reevaluations—average days overdue	122	44	78	167	10

Source: Statistical analysis performed in consultation with an OIG statistician.

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: November 10, 2021

From: Acting Under Secretary for Health, Veterans Health Administration (10)

Subj: OIG Draft Report, Inadequate Oversight of VHA's Home Oxygen Program (2019-07812-0003) (VIEWS 05733621)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Inadequate Oversight of VHA's Home Oxygen Program. The Veterans Health Administration (VHA) concurs with recommendations 1-3, considers them fully implemented and requests closure. VHA concurs in principle with recommendations 4-6 and provides action plans in the attachment.

The OIG removed point of contact information prior to publication.

(Original signed by)

Stephen L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Office of Inspector General (OIG) Draft Report Action Plan

Veterans Health Administration: Inadequate Oversight of VHA's Home Oxygen Program

(2019-07812-R3-0003)

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

Recommendation 1. Implement comprehensive guidance for staff who schedule home oxygen consults that includes processes for working with patients who do not or are unable to attend scheduled reevaluations, and for determining how and when to discontinue home oxygen services when appropriate.

VHA Comments: Concur. VHA will implement comprehensive guidance for staff who schedule home oxygen consults that includes processes for working with patients who do not or are unable to attend scheduled reevaluations, and for determining how and when to discontinue home oxygen services when appropriate. The following was added to the Clinical Indications link within the VHA Directive 1173.13, *Home Oxygen Program*, published on August 5, 2020, (see section 5. n. o. (1), on page 5):

(a) Follow-up evaluations (other than in e-1 and e-2 below, which are not required) should be accomplished within three months. If the patient misses or is unable to attend the re-evaluation scheduled, then the following guidance should be used.

> (1) For patients qualifying for home oxygen by resting hypoxemia, two additional appointments may be placed. However, if re-evaluation has not occurred within 6 months, then oxygen should be discontinued, if not done sooner.
>
> (2) For patients qualifying for home oxygen by desaturation with exercise, one additional appointment may be placed. However, if re-evaluation has not occurred within 4 months, then oxygen should be discontinued, if not done sooner.

The updated clinical indications will be uploaded by the linked SharePoint. An email communication notifying relevant stakeholders (e.g., Chiefs of Pulmonary Medicine, Sleep physicians (including non-pulmonary sleep providers), respiratory therapists and medical instrument technicians) in the field will be sent out to ensure all providers utilizing this guidance are made aware of these updates. VHA considers this recommendation fully implemented and requests closure.

Status: Complete Target Completion Date: October 2021

Recommendation 2. Update guidance to include any exceptions to the scheduling time frame based on the type of home oxygen services patients are prescribed.

VHA Comments: Concur. VHA will update guidance to include any exceptions to the scheduling time frame based on the type of home oxygen services patients are prescribed. As noted above in the response to Recommendation 1, the e-1 and e-2 refer to oxygen supplied for cluster headaches and sleep disordered breathing respectively. In September 2020, the following was added to the Clinical Indications link in VHA Directive 1173.13:

(1) Home oxygen therapy can be prescribed for hypoxemia associated with sleep-disordered breathing at the discretion of the Sleep physician after evaluation in Sleep Clinic. This should usually be prescribed in conjunction with positive airway pressure therapy; however, supplemental oxygen therapy alone may be

prescribed to treat a patient with central sleep apnea / Cheyne-Stokes respiration when positive airway pressure treatment is not efficacious or cannot be tolerated by the patient.

This update was uploaded by the linked SharePoint, followed by an email communication notifying relevant stakeholders in the field to ensure all providers utilizing this guidance were made aware of the update. VHA considers this recommendation fully implemented and requests closure.

Status: Complete Target Completion Date: October 2021

Recommendation 3. Update policy to assign oversight responsibility for ensuring the number of home or telehealth visits outlined in guidance is conducted.

VHA Comments: Concur. VHA will update policy to assign oversight responsibility for ensuring the number of home or telehealth visits outlined in guidance is conducted. The checklist link within VHA Directive 1173.13, section 5. j. (2), on page 3, has been updated to include the "Director/Chair of Home Respiratory Care Team" as the responsible person for oversight and there is a place for signature. This updated document will be uploaded by the linked SharePoint. An email communication notifying relevant stakeholders in the field will be sent out to ensure all providers utilizing this guidance are made aware of these updates. VHA considers this recommendation fully implemented and requests closure.

Status: Complete Target Completion Date: October 2021

Recommendation 4. Require the network contracting offices to provide oversight so that (1) contracting officers ensure vendor performance evaluations and quality assurance reports are completed and documented in the electronic contract management system, and (2) contracting officers comply with requirements when designating contracting officer's representatives.

VHA Comments: Concur in principle. The VHA Executive Director for Procurement will form a work group with appropriate key stakeholders such as VHA Procurement and Logistics Office, VHA Prosthetics, VHA Finance and VHA Respiratory Therapists to identify the root cause of insufficient home oxygen contract monitoring and deficient financial procedures and develop mitigation strategies to reduce the OIG findings. These strategies may include a statement of work template, financial procedures, and other contract monitoring tools.

Status: In progress Target Completion Date: August 2022

Recommendation 5. Clearly communicate processes or tools that staff should use to achieve the contract monitoring requirements outlined in the Federal Acquisition Regulation.

VHA Comments: Concur in principle. The VHA Executive Director for Procurement will form a work group with appropriate key stakeholders such as VHA Procurement and Logistics Office, VHA Prosthetics, VHA Finance, and VHA Respiratory Therapists to identify the root cause of insufficient home oxygen contract monitoring and deficient financial procedures and develop mitigation strategies to reduce the OIG findings. These strategies may include a statement of work template, financial procedures, and other contract monitoring tools.

Status: In progress Target Completion Date: August 2022

Recommendation 6. Ensure facilities in Veterans Integrated Service Network 7 review orders that were paid for home oxygen services without an awarded contract and submit a request for ratification to the head of the contracting activity for any unauthorized commitments.

VHA Comments: Concur in principle. The Assistant Under Secretary for Health for Operations in collaboration with the VHA Executive Director for Procurement will direct the VISN Director to ensure the facility(ies) review the orders in question and consult with the Office of General Counsel and Network

Contracting Office 7 to determine if a request for ratification to the Head of the Contracting Activity is required. If it is determined a ratification is required, the facility(ies) will comply with VA Directive 7401.7 and VA Acquisition Regulation 801.602-3 regarding submission of the required documentation.

Status: In progress Target Completion Date: January 2022

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

OIG Contact and Staff Acknowledgments

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