US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans

Management Advisory Memorandum	25-00261-169	September 17, 2025

BE A
VOICE FOR VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION
To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US


Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE
In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

QUALITY STANDARDS
The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation except for the standard of reporting.

July 2, 2025[1]

MANAGEMENT ADVISORY MEMORANDUM

TO: Dr. Steven L. Lieberman, Acting Under Secretary for Health, Veterans Health Administration (VHA)[2]

FROM: Larry Reinkemeyer, Assistant Inspector General, Office of Audits and Evaluations, VA Office of Inspector General (OIG)

SUBJECT: Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans

Many VA facilities offer residential substance use disorder treatment for veterans with mental health conditions like posttraumatic stress disorder, depression, and substance use disorder. While residential treatment is not available at a VA facility in every state, VA operates about 250 treatment programs at about 120 residential rehabilitation sites across the country, with enough beds to accommodate more than 6,500 veterans.[3] When VA cannot provide these services to a veteran within 72 hours for priority admission or within 30 days for routine admission, VA can refer the veteran to a community provider.[4]

This memorandum conveys information analyzed from fiscal years (FYs) 2023 and 2024 to help VHA determine whether additional actions are warranted to address significant cost concerns and potential issues related to patients' length of stay and the quality of care for residential substance use disorder treatment provided under Community Care Network (CCN) contracts.[5] The billing methodology used under these contracts for substance use disorder treatment has led to VA paying more for these services than it would have if they had been reimbursed at the rate paid for by another federal health benefits program. In addition, the OIG has identified patient care concerns that may merit further oversight. This memorandum helps quantify the potential

[1] This memorandum was sent to the Veterans Health Administration on July 2, 2025, to provide the opportunity to review and comment.

[2] This memorandum to the acting under secretary for health is directed to anyone performing the delegable duties of the position.

[3] "VA Mental Health Residential Rehabilitation Treatment" (web page), Mental Health, accessed March 28, 2025, https://www.mentalhealth.va.gov/get-help/va-residential-rehabilitation/index.asp.

[4] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

[5] The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or during its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

monetary impact of CCN contract deficiencies, nonadherence to guidance for billing standardized episodes of care, and lack of oversight of billing practices. Though the OIG understands that VA is already taking steps to address these concerns, VA's efforts must still be effectively and fully implemented with close monitoring. The OIG requests to be informed of any steps VHA takes in response to the information in this memorandum. The OIG is taking no additional action at this time.

The VA MISSION Act of 2018 established the conditions under which veterans are eligible for community care.[6] VA's Veterans Community Care Program allows VHA to contract with providers through the CCN for veterans who meet eligibility requirements.[7] The CCN was developed to improve coordination between VA and community providers. It groups VA medical facilities into five regions managed by two third-party administrators (TPAs), referred to as TPAs A and B for this memorandum. TPA A manages regions 1, 2, and 3; and TPA B manages regions 4 and 5.[8] The TPAs provide administrative and operational support for VHA community care programs, including processing and paying providers' claims. According to VA's CCN contracts, VHA is required to reimburse the TPAs for the amounts the TPAs paid to providers, up to the amount in the following applicable payment hierarchy:

1. **Medicare** for healthcare services in which payment can be made up to Medicare rates
2. **VA fee schedule** for healthcare services in which payment is based on the applicable VA fee schedule rate and should be used only if there is no Medicare rate available
3. **Percentage of billed charges** for healthcare services with neither Medicare nor VA fee schedule rates and payment is based on a percentage of billed charges (VA has

[6] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393. Under the MISSION Act, veterans are eligible to receive community care when a veteran's local VA medical facility does not provide the requested service or when a provider determines community care is in a veteran's best medical interest. Consideration is also given to wait times and drive times for appointments.

[7] Medical facilities can also enter into local veterans care agreements with community providers in limited situations where contracted services through the CCN are either not provided or not sufficient to ensure veterans can get the care they need. "Veterans Care Agreements," (web page), Community Care, accessed March 27, 2025, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[8] Each of the five regional contracts began with a base period of one year with seven renewable one-year options. According to a VA official, as of fall 2024, the contracts were worth about $193.5 billion.

not established a maximum or set percentage of billed charges for this step in the reimbursement hierarchy under the CCN contracts.[9])

As a general matter, a standardized episode of care has a defined period and scope during which a patient receives treatment for a specific medical condition. For the purposes of this memorandum, the OIG reviewed VA authorizations for which the TPAs were reimbursed in FYs 2023 and 2024 for residential substance use disorder treatment associated with a standardized episode of care, coded as "Mental Health Residential Treatment, 1.15," that establishes billing and care guidelines specific to the authorized care. An authorization for treatment should include a standardized episode of care that outlines the allowable length of a patient's stay, what treatment or services can be provided, and the relevant billing codes.

Because there is no Medicare rate for residential substance use disorder treatment, the next option in the payment hierarchy is the VA fee schedule. The standardized episode of care guidelines for substance use disorders outline treatment criteria and a list of billing codes that could be used by providers to seek payments under the VA fee schedule. However, the standardized episode of care was not specifically part of the claims reimbursement language in the contracts, and the OIG's analysis found the TPAs and providers have not generally been using these billing codes and the VA fee schedule. They had instead used the percentage of billed charges, resulting in VA overpaying for residential substance use disorder treatment.

The OIG found that more than 97 percent of the $1.3 billion that VHA reimbursed the TPAs in FYs 2023 and 2024 for residential substance use disorder treatment relied on the percentage of billed charges, compared to less than 1 percent billed under the VA fee schedule using the billing codes from the guidelines for standardized episodes of care.[10] Furthermore, because the CCN contracts did not establish a ceiling for the percentage of billed charges that the TPAs should pay providers, there was no rate control.[11]

To resolve this issue, VHA completed a contract modification with TPA B to implement the standardized episode of care billing codes. Before the modification with this TPA, the standardized episode of care was not specifically part of the claims reimbursement language in the contract. Subsequently, VHA also implemented a payment policy with TPA B to make sure reimbursements for residential substance use disorder treatment are made under the VA fee

[9] A previous OIG report has an open recommendation for VHA to develop contract language and/or maximum allowable rates to limit reimbursements that do not have a Medicare or VA fee schedule rate for CCN claims (step 3 in the payment hierarchy). Until this recommendation is fully addressed, VHA faces a heightened risk of paying excessive costs for treatment services. See the *Concerns About Reimbursement Practices* section in this report for further discussion of this risk. VA OIG, *Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*, Report No. 23-00748-28, February 20, 2025.

[10] All numbers in the report are rounded unless otherwise noted and therefore may not sum.

[11] The CCN contracts require TPAs to seek reimbursement from VHA for the same amount they pay providers up to the contract's allowed amount, with no profit added, for healthcare services.

schedule. That policy revision further clarifies billing policies and codes from the VA fee schedule, which determines the TPA's reimbursement rate. So, moving forward with TPA B, substance use disorder treatment should be paid according to the standardized episode of care using the codes and reimbursement rates from the VA fee schedule.

VHA has not implemented similar changes with TPA A. Until there is a uniform TPA policy with provisions for more effective oversight of adherence to billing code requirements or a ceiling on the rates for the percentage of billed charges, VHA remains at risk of making excessive payments when using a percentage of billed charges.

The potential monetary impact and other issues identified in this memorandum emphasize the need for VHA to closely monitor action to improve cost controls and policies related to adhering to billing codes with rate ceilings for residential substance use disorder treatment provided under the CCN contracts. The OIG acknowledges that VA aims to develop an updated reimbursement methodology by December 2025 for the next generation Community Care programs with rate limits for when a provider or TPA uses a percentage of billed charges (that is, when there is no VA fee schedule)—but VA has more work to do in ensuring effective implementation and oversight. The following sections discuss the concerns with insufficient cost controls for residential substance use disorder treatment services provided in the community and the potential monetary impact.

During site visits at two VA medical facilities in January 2025, the OIG identified concerns related to the duration of community residential substance use disorder treatment and the quality of care provided to veterans. Those concerns are detailed in a later section of this memorandum.

Of note, the OIG published a fraud alert in December 2024 to VA staff and the veteran community requesting help in reporting drug and alcohol treatment facilities that are attempting to exploit veterans with substance use disorders for profit through various unethical and illegal practices.[12] The OIG's Office of Investigations has been involved in a number of treatment facility investigations related to unlicensed providers billing fees and not delivering promised care to veterans; in April 2025, the OIG and the Department of Justice resolved False Claim Act allegations between VA and a drug and alcohol rehabilitation facility that resulted in a civil settlement of more than $19 million.[13]

[12] VA OIG, "Help Stop Scams Involving Substance Use Disorder Treatment" (fraud alert), December 2024.

[13] US Attorney's Office, District of New Jersey, "Cumberland County Drug and Alcohol Rehabilitation Center Agrees to Pay $19.75 Million to Resolve False Claims Act Allegation," press release, April 30, 2025, https://www.justice.gov/usao-nj/pr/cumberland-county-drug-and-alcohol-rehabilitation-center-agrees-pay-1975-million-resolve.

Program Oversight and Billing Process

Both VHA program offices and VA medical facilities are involved in overseeing the residential substance use disorder treatment program provided under the CCN contracts. Responsible VHA offices include the VHA Office of Mental Health and the VHA Office of Integrated Veteran Care (IVC).

VHA Office of Mental Health

The Office of Mental Health is responsible for improving the quality and availability of mental health services. This includes prevention strategies; outpatient, residential, and inpatient treatments; and recovery and rehabilitation services that address mental health and substance use disorders.[14]

Residential treatment is distinguished from outpatient, inpatient, and institutional extended care. Residential programs provide a structured 24-hour therapeutic environment to support veterans dealing with complex mental health and substance use disorders, medical issues, and challenges such as employment and housing stability. The primary goal of residential substance use disorder treatment is to promote recovery, improve daily life, and support community reintegration while reducing the chances of relapse and hospitalization.[15]

Within the Office of Mental Health, the national mental health director of substance use disorders is responsible for implementing the requirements of the VHA directive on substance use disorder programs. The directive provides guidance to ensure national policy and procedures for substance use disorder services align with practice standards. In addition, it requires the national director to provide consultation and guidance to regional Veterans Integrated Service Network leaders, VA medical facility leaders, and frontline staff to support evidence-based treatment for substance use disorders.[16]

VHA Office of Integrated Veteran Care

In June 2022, VHA finished reorganizing its Office of Community Care and Office of Veterans Access to Care to formally establish IVC to coordinate veterans' access to treatment from VA and community care providers. Within IVC, the group responsible for overseeing the CCN

[14] This management advisory memorandum refers to this program's treatment for substance use disorder as "residential substance use disorder treatment."

[15] For additional information on VA residential treatment programs, see "VA Mental Health Residential Rehabilitation Treatment" (web page), Mental Health, accessed June 30, 2025, https://www.mentalhealth.va.gov/get-help/va-residential-rehabilitation/index.asp.

[16] VHA Directive 1160.04(1), *VHA Programs for Veterans with Substance Use Disorders*, December 8, 2022, amended July 25, 2024. VHA divides the United States into 18 regional networks, known as Veteran Integrated Service Networks, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

contracts is the Office of Integrated External Networks, which develops and monitors contracts for veterans' healthcare services and reimburses the TPAs for care provided under the CCN contracts.

VA Medical Facilities

VA medical facility directors are tasked with making sure veterans diagnosed with a substance use disorder have access to the full range of mental health and medical services, including ensuring the availability of residential substance use disorder treatment. As previously mentioned, VA medical facilities authorize community care under a CCN contract if VA cannot provide the care within 30 days.[17] Various events can initiate a community care authorization for substance use disorder services, such as an inpatient admission or emergency department visit, a new veteran clinical appointment, a hospital notification, or a referral from a VA or community healthcare provider. It is the responsibility of each VA facility's community care team to assign staff to manage authorizations, confirm eligibility, and authorize the services indicated in a consult.

Community Care Reimbursement System

The Community Care Reimbursement System is the automated processing system for CCN claims. TPAs submit healthcare claim information electronically to VHA, and when the Community Care Reimbursement System receives the information, the claim is processed as an invoice for reimbursement to the TPA. However, the system has no function to review TPA invoices to make sure the TPAs paid the contract rates that apply to how much a provider can bill. Instead, VHA relies on the TPAs to pay providers' claims at the established contract rate and reimburses each TPA for the invoiced charges as submitted, without checking whether the rate billed by the provider is correct.[18]

What the OIG Did

The OIG team visited two VA healthcare system sites in January 2025: the VA Greater Los Angeles Healthcare System, which included the Sepulveda and West LA campuses, and the Bay Pines VA Healthcare System in Florida.[19] At these facilities, the team interviewed staff responsible for managing the CCN program. They also interviewed program staff from the Office of Mental Health. To assess the cost of residential substance use disorder treatment in the

[17] VHA Directive 1162.02.

[18] The contracts also require TPAs to hire a third party to conduct quarterly audits to identify opportunities to recover overpayments. VHA is responsible for monitoring contract financial management controls and for reviewing and certifying acceptance of the third-party auditor's overpayment recoveries.

[19] The OIG judgmentally chose these two sites based on higher residential substance use disorder treatment utilization and costs.

community, the OIG team reviewed CCN claims from TPA A's regions 1–3 and TPA B's region 4 for treatment that occurred and was paid for in FYs 2023 and 2024, totaling about $1.3 billion in reimbursements.[20]

Community Residential Substance Use Disorder Treatment

Under the CCN program, 10,221 distinct veterans received residential substance use disorder treatment in FYs 2023 and 2024. There were 14,994 distinct authorizations for their care over the same period. Table 1 breaks down the veterans and authorizations by TPA.

Table 1. Distinct Veterans and Authorizations for Residential Substance Use Disorder Treatment Provided Under CCN Contracts for FYs 2023 and 2024

Category	TPA A	TPA B	Overall
Distinct veterans	4,038	6,224	10,221*
Distinct authorizations	5,336	9,658	14,994

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN regions 1–4.

** Distinct veteran counts do not sum to the overall total because some veterans received care from more than one TPA.*

Looking at data for residential substance use disorder treatment during FYs 2023 and 2024, the OIG then calculated that VHA reimbursed the TPAs:

- about $1.3 billion total,
- an average of $2,766 per day, and
- an average of $129,382 per distinct veteran.

Tables 2–4 break down these calculations in greater detail.

Table 2. Expenditures for Residential Substance Use Disorder Treatment Provided Under CCN Contracts

TPA	FY 2023	FY 2024	Total
TPA A	$271,348,236	$183,145,537	$454,493,773
TPA B	$470,308,974	$397,612,352	$867,921,326
Total	**$741,657,211**	**$580,757,889**	**$1,322,415,100**

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN regions 1–4.

Note: Totals may not sum due to rounding.

[20] TPA B region 5 (Alaska) did not have any claims for residential substance use disorder treatment under CCN contracts for FYs 2023 and 2024.

Table 3. Average Cost Per Day for Residential Substance Use Disorder Treatment Provided Under CCN Contracts

Category	FY 2023	FY 2024	Overall
TPA A	$2,548	$2,740	$2,622
TPA B	$2,746	$2,980	$2,848
Overall	$2,670	$2,900	$2,766

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN regions 1–4.

Note: Averages may not sum, as each is calculated from a distinct set of underlying values.

Table 4. Average Cost Per Veteran for Residential Substance Use Disorder Treatment Provided Under CCN Contracts

Category	FY 2023	FY 2024	Overall
TPA A	$103,965	$105,803	$112,554
TPA B	$117,372	$127,481	$139,001
Overall	$112,543	$120,016	$129,382

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN regions 1–4.

Note: Averages may not sum, as each is calculated from a distinct set of underlying values.

Tables 5 and 6 present data from FYs 2023 and 2024 for the two healthcare system sites the team visited. For the Greater Los Angeles system (table 5), the OIG calculated that community residential substance use disorder treatment for 425 distinct veterans (with 671 distinct authorizations) yielded an average cost per day of $2,995 and a total average cost per veteran of $112,551.

Table 5. Greater Los Angeles Estimated Distinct Veterans, Authorizations, and Expenditures for Residential Substance Use Disorder Treatment Provided Under CCN Contracts

Category	Facility count or cost
Distinct veterans	425
Distinct authorizations	671
Average cost per day	$2,955
Average cost per veteran	$112,551
Total cost for treatment	$47,834,210

Source: OIG analysis of paid CCN claim data for treatment provided in FYs 2023 and 2024 for CCN region 4, TPA B.

For the Bay Pines system, the OIG calculated that community residential substance use disorder treatment for 121 distinct veterans (with 156 distinct authorizations) yielded an average cost per day of $2,898 and a total average cost per veteran of $120,919.

Table 6. Bay Pines Estimated Distinct Veterans, Authorizations, and Expenditures for Residential Substance Use Disorder Treatment Provided Under CCN Contracts

Category	Facility count or cost
Distinct veterans	121
Distinct authorizations	156
Average cost per day	$2,898
Average cost per veteran	$120,919
Total cost for treatment	$14,631,235

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN region 3, TPA A.

Concerns About Reimbursement Practices

As noted earlier, community providers delivering residential substance use disorder treatment did not use the billing codes documented in the standardized episode of care guidelines; without the billing codes, the VA fee schedule cannot be used.[21] To estimate the potential level of overpayment resulting from this, the OIG used TRICARE's per diem cap rate as a benchmark for a more consistent approach to estimate reimbursement for residential substance use disorder treatment. The OIG chose TRICARE because it is a federal health benefits program for uniformed service members and their eligible family members that, like VA, also provides services to veterans, such as retirees. Also like VA, TRICARE provides services through a mix of Department of Defense and VA facilities, as well as community care.[22] TRICARE also establishes standardized reimbursement rates. Using TRICARE's per diem cap rate (discussed in the next section) as a benchmark rate, the OIG determined most of the $1.3 billion VHA reimbursed to the TPAs under the percentage of billed charges resulted in VHA payments in excess of what TRICARE would have paid.

[21] Because the billing codes in the specialized episode of care were not followed, it is difficult to use the VA fee schedule rates to calculate reimbursements. For example, VA's fee schedule has over 100 localities, each with a unique rate for each of the three codes in the specialized episode of care. In FYs 2023 and 2024, reimbursement rates ranged from an average of $982 to $1,778, with an overall average of $1,252.

[22] TRICARE is the Department of Defense's healthcare program for active-duty service members, active-duty family members, National Guard and Reserve members and their family members, retirees and retiree family members, survivors, and certain former spouses. "Plans & Eligibility" (web page), "TRICARE," accessed April 3, 2025, https://tricare.mil/Plans/Eligibility.

Under the CCN contracts, TPA A generally pays providers at 100 percent of billed charges (that is, the full amount billed) and then seeks reimbursement for residential substance use disorder treatment from VHA for that amount. TPA B generally pays providers at 75 percent of billed charges and then seeks reimbursement for that amount from VHA.[23]

Fewer than 1 percent of reimbursements to TPA B and none from TPA A were based on providers using billing codes identified in the standardized episode of care guidelines. Even though TPA B was paying providers at 75 percent of billed charges, it still resulted in excessive reimbursement rates when compared with TRICARE. Providers set their own charges, and it is possible VA's policy to pay at billed rates encourages price increases.

As noted in table 3, the average cost per day was higher for TPA B at $2,848 than for TPA A at $2,622—which means TPA B's average payments to providers billing at a 75 percent rate was higher than the average amount paid by TPA A at 100 percent. Additionally, the reimbursements are not based on a maximum allowable rate to contain or reduce costs, which could lead to unpredictable and excessive spending. The OIG found that VA reimbursements to TPAs for payments made to treatment providers varied, reaching per-day costs of up to about $6,000 for TPA B and about $7,000 for TPA A under the CCN contracts.

Impact of Reimbursing at Billed Charges

To calculate the potential monetary impact of VHA reimbursing TPAs for payments to residential substance use disorder treatment providers in the amount of billed charges, the OIG team compared VHA reimbursement rates for FYs 2023 and 2024 to TRICARE reimbursement rates for the same two years.[24] Because TRICARE sets fixed rates to control costs for residential substance use disorder treatment, the OIG determined TRICARE's per diem cap rate—$1,093 in FY 2023 and $1,130 in FY 2024—was a comparable benchmark to measure potential cost savings for this type of care against current VHA reimbursement practices.[25]

The OIG's analysis showed that VA's reimbursements for this treatment are usually higher because the percentage of billed charges often amounts to more than TRICARE's fixed rate. Using TRICARE's standardized rate for residential treatment centers as a point of comparison,

[23] The discrepancy in billing and reimbursements as a percentage of billed charges between the two TPAs for the same service is not reflected in the contracts and was not revealed to the OIG team. Further inquiries were outside the scope of this memorandum.

[24] The guidelines for the standardized episode of care listed several billing codes associated with a VA fee schedule rate and, if used in a claim, could have reduced costs. However, since the vast majority of claims did not include these codes, they could not be easily applied to determine reimbursement. Therefore, using the TRICARE per diem cap rate as a benchmark allowed for a more consistent approach to estimating reimbursement for residential substance use disorder treatment. In addition, VA has since taken action to implement a new payment policy.

[25] "Mental Health and Substance Use Disorder Facility Rates" (web page), TRICARE Health Plan, Military Health System, accessed April 4, 2025, https://www.health.mil/military-health-topics/access-cost-quality-and-safety/tricare-health-plan/rates-and-reimbursement/MHSUD-facility-rates.

the OIG's calculations found that VHA reimbursed TPAs about $807 million more for residential substance use disorder treatment center services. Table 7 shows the amounts reimbursed to each TPA for each fiscal year that exceeded TRICARE rates.

Table 7. Amount Reimbursed in Excess of TRICARE's Residential Treatment Center Rates

TPA	FY 2023	FY 2024	Overall
TPA A	$158,896,095	$109,543,330	$268,439,425
TPA B	$288,682,578	$249,500,979	$538,183,557
Totals	**$447,578,672**	**$359,044,309**	**$806,622,981**

Source: OIG analysis of paid CCN claims data for treatment provided in FYs 2023 and 2024 for CCN regions 1–4.

VHA's Steps to Address Concerns

On October 4, 2024, a Strategic Acquisition Center (SAC) official signed a contract modification with TPA B for region 4 to establish and implement a new payment policy to control costs in general (not specific to substance use disorder treatment). Additionally, on November 15, 2024, IVC finished developing a formal policy addressing the payment requirements for residential substance use disorder treatment, with updated provider billing requirements and claim submission processes. According to IVC, the completed substance use disorder treatment payment policy was provided to TPA B on January 14, 2025, with implementation completed as of May 2025. However, according to a SAC official, IVC had not successfully implemented changes with TPA A.

The OIG asks VA to consider a two-pronged approach. First, VA should more effectively enforce the use of billing codes in the standardized episode of care guidelines by TPAs and providers. IVC should review its CCN contracts and determine whether additional actions are needed to ensure full implementation and adequate oversight to enforce those contracts.

Second, VHA should examine its plan to put ceiling rates on the percentage of billed charges when the VA schedule cannot be used. VHA has been addressing past OIG report recommendations related to the lack of cost controls for CCN reimbursements made using a percentage of billed charges. A report on overpayment of dental fees made the following recommendation to the under secretary for health:

> Make sure the Office of Integrated Veteran Care develops contract language and/or maximum allowable rates to limit reimbursements that do not have a Medicare or VA fee schedule rate for Community Care Network claims.[26]

In response to the recommendation, VHA's action plan stated,

> The Office of Integrated Veteran Care (IVC) created maximum allowable rates to be used when Medicare rates are not available. The Department of Veterans Affairs (VA) rate setting utilizes industry benchmarks and scans for services not covered by Medicare or prior VA fee schedule services to ensure services have a maximum allowable and industry-based rate to the extent possible. IVC will develop proposed contract language that clearly defines reimbursement limits when Medicare and VA fee schedules do not apply.

VHA's target completion date to implement its plan is December 2025. Whether policy changes resolve the problem still depends on VHA's full implementation of the OIG recommendation as well as clear guidance, continuous monitoring, and quality assurance.

Concerns About Duration and Quality of Treatment

The standardized episode of care guidelines set a 45-day duration for residential substance use disorder treatment in the community.[27] During the OIG team's site visits in January 2025, VHA clinicians expressed concerns related to the duration and quality of care. In their experience, community providers often allowed veterans to stay for the entire 45-day duration for treatment, which was not always needed. Staff at both facilities the team visited noted that, based on clinical assessments, this might not reflect individual treatment needs, highlighting potential inefficiencies in the one-size-fits-all authorization model used. For example, according to the program manager for the Bay Pines facility, residential substance use disorder treatment rarely requires veterans to stay 45 days, and clinicians at both facilities noted that more than 30 days is not always required. They recommended that the standardized episode of care guidelines provide an option to adjust the treatment duration based on a clinical assessment of a veteran instead of setting it at 45 days.

Clinicians at both VA healthcare systems visited also voiced concerns about the lack of medical oversight in community residential programs. They said, for example, that veterans may return to VA outpatient care from residential community care after being prescribed benzodiazepines.[28] A

---

[26] VA OIG, *Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*.

[27] "Mental Health Residential Treatment, 1.15."

[28] "Benzodiazepines are widely used in the treatment of anxiety, sleep, depression (as adjuvant therapy), and as muscle relaxants." "Benzodiazepines" (web page), Pharmacy Benefits Management Services, accessed March 27, 2025, https://www.pbm.va.gov/PBM/academicdetailingservice/Benzodiazepines.asp.

clinician at the Greater Los Angeles Healthcare System was among those who told the team that some community providers prescribe benzodiazepines, even though they are typically not used in VHA during substance use disorder treatment because they are addictive and can be dangerous if a veteran relapses with alcohol.

The program manager at the Bay Pines system said his facility focuses on evidence-based practices—such as motivation enhancement therapy—to treat substance use disorders. According to VHA guidance, these practices

> have been shown to improve a variety of mental health conditions and overall well-being. These treatments are tailored to each Veteran's needs, priorities, values, preferences, and goals for therapy … [and] often work quickly and effectively, sometimes within a few weeks or months, depending on the nature or severity of [their] symptoms.[29]

The Bay Pines program manager stated,

> Our experience is that we have no idea what type of therapy is being provided at the Community Care programs. We have no idea what practices [they] are using and what level of licensed and experienced providers they may have. Our SUD [substance use disorder] services have licensed, trained and experienced providers. … We provide the veterans with Evidenced Based practices and have tools to evaluate the veterans [*sic*] progress throughout their treatment experience to measure their response to treatment and adjust with the veteran as needed. We have no knowledge of what is or is not being offered to the Community Care programs. It would be helpful to know this and require that the Community Care Programs are providing Evidenced Based Practices with licensed and experienced staff. This is an idea about quality control for the benefit of the veteran.[30]

The program manager noted Bay Pines' residential substance use disorder treatment is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and suggested community providers' programs should be too.

> VHA Residential programs are required to be CARF accredited. Obtaining this accreditation truly improved and pushed our program into a process of maintaining and continually improving the quality of the residential treatment services from the physical environment to the scope of and delivery of treatment services. It requires that the accredited program delivers services in a recovery-oriented fashion. Our MH RRTP [Mental Health Residential

[29] "Evidence-Based Therapy" (web page), VA Mental Health, accessed March 13, 2025, https://www.mentalhealth.va.gov/get-help/treatment/ebt.asp.

[30] Email statement from the program manager for VA's residential substance use disorder treatment program in Bay Pines, Florida.

> Rehabilitation Treatment Program] programming has been improved and enhanced by becoming [accredited] and maintaining CARF accreditation. We would be surer that veterans would be receiving a higher quality of care in CARF accredited programs.[31]

Clinicians at both the Los Angeles and Bay Pines healthcare systems recommend an accreditation requirement for community residential substance use disorder treatment programs to improve the quality of such care.

Conclusion

Failing to make sure providers who treat veterans with substance use disorders in a residential setting use designated billing codes—combined with VA's lack of a maximum allowable rate when resorting to a percentage of billed charges—risks excessive costs. VA needs to enforce appropriate limits on reimbursements for substance use disorder treatment under the CCN contracts or evaluate its procedures for using billing codes associated with specific standardized episodes of care. Until this occurs, VA will continue to overpay for these services.

Further, without proper oversight by TPAs, VHA could continue to overpay for services and divert resources that would otherwise be used for veterans' health care. Additionally, inadequate controls increase the opportunity for some providers to bill for unnecessary treatment, potentially lengthening the duration of veterans' stays needlessly. Site visits and interviews also revealed a need for greater oversight of the quality of care veterans receive in residential substance use disorder treatment. Strengthening oversight is essential to mitigate financial risk, ensure program integrity, and safeguard the delivery of high-quality care to veterans.

Requested Action

VHA has already taken steps to develop a new payment policy for residential substance use disorder treatment and completed a contract modification with TPA B for treatment provided under its CCN contract that clarifies the use of billing codes for the VA fee schedule. In addition to ensure compliance with the TPA B contract modification and updated payment policy, VHA should ensure full implementation of the changes and provide ongoing oversight in current and future TPA contracts to monitor whether the payment policies effectively control costs.

VHA may also want to consider consulting with mental health staff at the authorizing VA facilities to obtain their feedback on how to improve quality of care and program outcomes for veterans seeking residential substance use disorder treatment under CCN contracts.

[31] Email statement from the program manager for VA's residential substance use disorder treatment program in Bay Pines, Florida.

VA Management Comments

Since the OIG does not make recommendations in a management advisory memorandum, no response was required. However, the acting under secretary for health provided a note, which is included in appendix A.

Appendix A: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 25, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment (VIEWS 13378647).

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment.

2. The Veterans Health Administration (VHA) greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD, MBA, FACHE

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

Contact	For more information about this management advisory memorandum, please contact the Office of Inspector General at (202) 461–4720.
Review Team	Jennifer L. McDonald, Director Lila Davis Chris Enders
Other Contributors	Andrew Eichner Vassili Khristoforov Bill Warhop

Management Advisory Memorandum Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of Public and Intergovernmental Affairs
Office of General Counsel
Office of Congressional and Legislative Affairs
Office of Accountability and Whistleblower Protection

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.

OIG reports and memoranda are available at www.vaoig.gov.