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Veteran Directed - Home and Community Based Services (VD-HCBS) Overview

Veteran Directed - Home and Community Based Services (VD-HCBS) is a home and community based service (HCBS) for Veterans who need significant support to remain safely in the community. As a participant-directed program it allocates a budget to the Veterans to pay for their care. The amount of this budget is based on their score on the Purchased HCBS Case Mix and Budget Tool. Further, VD-HCBS operates as a partnership between the local Veterans Affairs Medical Centers (VAMC) and the local Aging and Disability Network. As a result, all bills for this program are generated by the Aging and Disability Network Agency.

This procedure guide provides an overview of a standardized new claim processing requirements for all VD-HCBS claims processed with a date of service on or after February 1, 2015.

Policy Change

Since Veterans can pay for a wide range of goods and services with their budget, the VA has been working with various approaches to billing for VD-HCBS services since the program’s inception in 2009. Now, all billing will have to follow the procedures described in this document. All VD-HCBS claims with dates of service on or after February 1, 2015, must use the procedures described here. Claims with dates of service prior to February 1, 2015 will be processed based on local procedures that were in effect prior to November 1, 2014. This rule change does not impact current contracts or sharing agreements that VAMCs may currently have in place, created prior to February 01, 2015.
While a Veteran receiving VD-HCBS may benefit from a wide range of self-directed services, bills from the Aging and Disability Network provider will all fall under one of two services.

**Personal Care Services** are services provided to support the health and wellbeing of an individual in their home. For VD-HCBS, all services that support the Veteran during the billing period will be combined and billed as a daily average cost. These will include the monthly costs incurred by the Aging and Disability Agency.

**Service Assessment/plan of care development** (case management) are the initial assessment and case set-up fees that go to the Aging and Disability provider as a one-time payment at the beginning of VD-HCBS services being provided. These include a partial assessment fee for Veterans who use the services of the Aging and Disability provider but do not enroll in VD-HCBS or a full Service Transition and Assessment Reimbursement (STAR) for Veterans who enroll in the program.

**Exemptions from VD-HCBS Billing**

There are no exceptions for VD-HCBS. All services delivered must be billed as one of the two services listed above.

**Entering a VD-HCBS Authorization**

- VD-HCBS must be pre-authorized by the VAMC, although the authorization does not need to be from a physician. The authorization will come from the VD-HCBS Program Coordinator at the VAMC and will include:
  - The Amount of the STAR and Partial Assessment fee.
The Veteran’s yearly allocation (Note: monthly bills may be more or less than the allocated amount since Veterans may underspend in one - or more - months in order to be able to make a large expenditure which supports their care)

Refer to the Purpose of Visit (POV) Information & Table for a complete list of codes.

**VD-HCBS Acronyms & Terminology**

The following list of acronyms and terminologies is specific to the VD-HCBS program.

**Aging and Disability Network Agency** – The local agency who is designated as a provider by the VAMC that provides Options Counseling and Financial Management Services to the Veteran.

**Budget** – The monthly amount allocated for the Veteran to spend to acquire their long-term care services and supports.

**Financial Management Services** – Financial Management Services (FMS) are those services that assist Veterans’ managing their budgets. FMS provide payroll services to assure that hired workers are paid appropriately and reimburse purchases of the Goods and Services using the Spending Plan as the guide to determine which services are authorized by the VAMC. Fees for the FMS are included in the Aging and Disability Network provider’s administrative fees.

**Goods and Services** – Goods and Services refer to items in a Spending Plan which includes professional services (other than Direct Care) as well as supplies and durable goods which support the Veteran’s safety, wellbeing and independence. All purchases of Goods and Services are approved by the VAMC VD-HCBS Coordinator when they approve the Spending Plan.
Monthly Administrative Fees – Agency Administrative Fees as monthly fees paid to the Aging and Disability Network Agency to pay for their provision of direct services to the Veteran. These fees are set by the VA and are included in the agreement between the VAMC and the local Aging and Disability provider. They come out of the Veteran’s Budget and are reflected in the Spending Plan.

Options Counseling – Veterans in VD-HCBS receive direct support from the Aging and Disability Agency in the form of an individual who carries out the person-centered assessment, assists in the development of the Spending Plan and periodically monitors the Veteran’s wellbeing. This person is referred to as the Options Counselor.

Participant Direction: Participant Direction is a method of providing long-term services and supports (LTSS) where Veterans receiving the services are given a high level of choice in determining their service package. This includes hiring their own workers and purchasing goods and services from a pre-determined budget and spending plan. In Participant Direction the Veteran receiving the services or their designated representative is the employer or co-employer of the workers who care for the Veteran.

Personal Care Services – In a Spending Plan, Personal Care Services are hands-on care provided by a worker hired by the Veteran or the Veteran’s representative.

Purchased HCBS Case Mix and Budget Tool – An assessment tool which determines the Veteran’s level need for home services. That need level, in turn, determines the amount of the Veteran’s Budget and associated STAR Fee.

Savings – Money that a Veteran does not spend from his or her Budget in a given month may, within limits, be kept available to the Veteran in the form of savings. The actual savings are held by the VAMC but the accounting related to the savings is maintained by the FMS. Savings may include

- Specified savings which are savings to make a planned large purchase (such as a home modification) or
Emergency savings which are savings for unexpected expenses, such as increased care hours should the Veteran fall ill.

**Spending Plan** – An individualized plan based on a person-centered assessment process which describes how the Veteran will use the budget each month. The Aging and Disability Agency, working with the Veteran or their designated representative, develops the spending plan before transmitting the plan to the VAMC for approval. The spending plan may include personal care, goods and services, savings and agency administrative fees.

**VD-HCBS Features**

VD-HCBS is a participant directed program where the Veteran is awarded a budget based on his or her care needs. The Veteran then develops a spending plan to determine how the budget will be used. As a participant-directed program, Veterans in VD-HCBS hire the workers who provide their personal care, determining the hours they work and their wages. The Veteran may also purchase goods and services to help meet their needs.

Veterans in VD-HCBS are supported by Options Counseling and FMS provided by an Aging and Disability Network provider who is identified by the VAMC.

Distinct features of VD-HCBS include:
Partnership between Local VAMCs and Aging and Disability Network Agencies

While VD-HCBS is a service of the Veterans Health Administration (VHA), direct Veteran oversight and support is provided by a local Aging and Disability Network Agency. These agencies go through a process to determine their readiness to support Veterans in the program and are designated by the local VAMC as Providers.

Budget Determination Using the Purchased HCBS Case Mix and Budget Tool

At the time of referral to VD-HCBS, the VAMC determines the Veteran’s budget through the use of the Purchased HCBS Case Mix and Budget Tool. The Purchased HCBS Case Mix and Budget Tool is used to determine the Veteran’s levels of need with an assigned budget category to that need level. The specific budget amounts vary locally and are set by the VA based on local wage rates for care as determined by the Centers for Medicare and Medicaid Services (CMS).

STAR and Partial Assessment Fee

Upon completion of the Spending Plan and the beginning of services, the Aging and Disability Network Provider may bill a Service Transition and Assessment Reimbursement or STAR Fee. This is designed to cover costs associated with transition and admission of a new referral. However, since VD-HCBS requires Veterans take significant responsibility for managing their care, some Veterans may, upon learning the details of the program, choose not to enroll. In that case, the Aging and Disability Network provider may bill for a Partial Assessment Fee to cover the costs of their working with the Veteran.

Monthly Per-Diem Billing Based on Actual Spending

VD-HCBS Personal Care Services are billed on the basis of a per-diem charge which is based on the actual costs the
Veteran generated in a given month divided by the number of days in the month that the Veteran received services. A Veteran will rarely spend exactly their budget amount in a given month. Actual spending may vary depending on days of the month, the amount of care a Veteran received in a given month and whether the Veteran is adding to or drawing down his or her savings. As a result, the per diem amount that is billed will vary from month to month.

**Monthly Expense Report**

Each month, the VD-HCBS coordinator at the VAMC receives a detailed report of the Veteran’s spending for the previous month which spells out all the hours of care the Veteran received and the wage rate, all purchases of goods and services the Veteran may have made, all savings accrued and spent, and all administrative fees. If the VD-HCBS Program Coordinator sees a discrepancy between the spending plan and what was actually spent over the course of the month, the Program Coordinator will direct the Aging and Disability Network provider to review the case mix spending plan and, when appropriate, adjust to reflect the care needs of the Veteran.

**Reconciliation at the End of Services**

When a Veteran leaves VD-HCBS for whatever reason, the Aging and Disability Network Provider may have excess funds at the time of their final bill. The local VD-HCBS coordinator will take that into account when reviewing the final Quarterly Report from the Aging and Disability Provider and coordinate with their business office to issue a bill of collection.
Billing Responsibilities of the VAMC and the Aging and Disability Network Agency

The VAMC is responsible for:
- Identifying and referring Veterans to VD-HCBS
- Determining the Budget amount using the Purchased HCBS Case Mix and Budget Tool
- Developing an agreement with the local Aging and Disability Network to designate them a provider of VD-HCBS services
- Reviewing quarterly reconciliation reports to assure appropriate expenditure of funds
- Reimbursing the provider in a timely and accurate manner

The Aging and Disability Network Agency is responsible for:
- Assisting the Veteran in developing a spending plan using person centered approaches
- Educating and supporting the Veteran in the role of employer
- Providing Financial Management Services
- Engaging in on-going monitoring of the Veteran’s receipt of services and their wellbeing
- Billing the VA timely and accurately
- Developing and submitting monthly detailed expense reports to the VAMC VD-HCBS Coordinator
T1020 – Personal Care Services

All expenses that relate to the care of the Veteran, including the Aging and Network Agency’s administrative fees, are billed under this code. The description of how the per diem rate is determined can be found on pages 5 - 6 under "Monthly Per-Diem Billing Based on Actual Spending."

T2024 – Service Assessment/plan of care development

The Partial Assessment Fee and the STAR will be billed here, with whether the bill is for the Partial Assessment Fee or the STAR to be noted in the “comments” section.

For further guidance on completing the Centers for Medicare and Medicaid Services (CMS) – 1450 Form, please refer to Medicare Claims Processing Manual Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

Resources

Case Mix and Budget Tool

Medicare Claims Processing Manual Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

Purpose of Visit (POV) Information & Table