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GAO

Report to Congressional Requesters

March 2006

VA LONG-TERM CARE

Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes

GAO-06-264

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GAO Accountability·Integrity·Reliability

Highlights

Highlights of GAO-06-264, a report to congressional requesters

Why GAO Did This Study

The Department of Veterans Affairs (VA) provides or pays for veterans' nursing home care in three settings: VA-operated nursing homes, privately owned nursing homes in the community from which VA purchases services, and state veterans' nursing homes. VA supports state veterans' nursing homes in a number of ways, including reimbursement for a portion of the cost of providing nursing home services to veterans, issuance of policy guidance, and oversight of their nursing home operations.

GAO was asked to determine the extent to which VA collects information on veterans in state veterans' nursing homes and the type of care they receive, to assess whether VA's reimbursement policy has been applied consistently, and to identify revenue sources such homes use.

What GAO Recommends

To promote adequate strategic planning and stronger oversight, GAO recommends that VA compile and report data on state veterans' nursing home populations and clarify certain aspects of its reimbursement policy. VA stated that it agreed with GAO's overall findings and generally concurred with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-264.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie E. Ekstrand (202) 512-7101 or ekstrandl@gao.gov.

What GAO Found

VA does not compile information on key characteristics of veterans receiving care in state veterans' nursing homes: veterans' length of stay, priority group status for VA hospital and outpatient services, age, and gender. VA needs such information for strategic planning, in order to develop baseline data of characteristics of veterans in state veterans' nursing homes and the care provided to them, which can help VA estimate the proportion of nursing home need it currently meets and the need it may be asked to meet as the number of older veterans changes over time. Based on visits to four states—Florida, Maine, Oklahoma, and Pennsylvania—GAO obtained information on key characteristics of state veterans' nursing home populations, which showed that these populations differed to varying degrees across the states. For example, state veterans' nursing homes in three of the four states generally were providing long-stay care (90 days or more), but 60 percent of stays in state veterans' nursing homes in Maine were short (less than 90 days).

GAO also found that certain aspects of VA's per diem reimbursement policy had not been applied consistently. For example, a VA medical center in one of the four states GAO visited approved reimbursement only for care provided to veterans admitted to state veterans' nursing homes who have had wartime military service. VA's policy does not limit reimbursement on this basis. GAO also found that VA headquarters officials have not been consistent in explaining to VA medical centers whether they could approve reimbursement to state veterans' nursing homes for care provided to veterans determined to have lowest priority for VA hospital and outpatient services.

In the states that GAO visited, state veterans' nursing homes rely on VA and non-VA revenue sources to varying degrees. In fiscal year 2004, per diem reimbursement from VA accounted for about one-fourth to one-third of revenues used for veterans' care. In addition to revenue from VA, state veterans' nursing homes in two of the four states GAO visited received reimbursement from Medicare and Medicaid for inpatient nursing home care provided to veterans. State veterans' nursing homes in three of the four states received funding directly from their states, ranging from 54 percent to 10 percent of revenues used for veterans' care in fiscal year 2004. In all the states GAO examined, the remainder of revenues comes from veterans' resources, such as Social Security and private pensions.

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Abbreviations

CARES	Capital Asset Realignment for Enhanced Services
CMS	Centers for Medicare & Medicaid Services
VA	Department of Veterans Affairs

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

March 31, 2006

The Honorable Larry E. Craig
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Christopher H. Smith
House of Representatives

The Department of Veterans Affairs (VA) operates a nursing home program that provides or pays for veterans' care in three different settings: VA nursing homes operated directly by VA, privately owned nursing homes in the community from which VA purchases services, and state veterans' nursing homes. State veterans' nursing homes, which numbered 116 by the close of fiscal year 2005, are joint federal-state partnerships in which VA pays a portion of the cost of providing nursing home care for eligible veterans in these homes,[1] provides grants to cover part of the cost of construction, acquisition, or renovation of these homes, and has oversight responsibilities for certain aspects of costs and services. By fiscal year 2003, state veterans' nursing homes had become responsible for the largest share of VA's nursing home workload[2] among the three settings of VA's nursing home program. In fiscal year 2005, state veterans' nursing homes accounted for almost 52 percent of VA's nursing home workload. In contrast, about 35 percent of the workload was provided in VA-operated nursing homes and about 13 percent was provided in privately owned nursing homes from which VA purchases services. That same year, VA spent about $382 million to support the delivery of care to veterans in state veterans' nursing homes and over $123 million to support capital construction and renovation in 23 states.

[1]VA supports the nursing home care provided to eligible veterans in state veterans' nursing homes through per diem reimbursements to these homes. Per diem reimbursements are based on the number of veterans in each home who are (1) discharged under conditions other than dishonorable and (2) certified by a physician as needing nursing home care.

[2]Nursing home workload is measured in terms of average daily census, which reflects the average number of veterans receiving nursing home care on any given day during the course of the year.

In 2004, we reported, in part, that VA lacked key information on veterans in state veterans' nursing homes, as well as on the type of nursing home care delivered in this setting.[3] We found that VA did not collect data on the proportion of veterans in state veterans' nursing homes for whom VA is required to provide nursing home care in accordance with the Veterans Millennium Health Care and Benefits Act[4] (Millennium Act veterans), as well as other veterans for whom VA provides such care on a discretionary basis. We also found that VA did not collect data on the extent to which veterans in state veterans' nursing homes received long-stay, chronic nursing home care that typically lasts 90 days or more, nor did VA collect data on short-stay, postacute nursing home care that typically lasts less than 90 days. In contrast, we found that VA collects such data from VA-operated nursing homes, both on the number of Millennium Act veterans and other veterans in these homes and on the extent to which veterans in this setting receive long and short-stay nursing home care. We concluded that VA's lack of uniform, comparable data across the three settings of its nursing home program impeded VA's strategic planning for nursing home care. As a result, we recommended that VA collect data on the number of Millennium Act veterans and other veterans receiving care in state veterans' nursing homes and the type of care they receive. VA concurred in principle with our recommendations.

In commenting on our 2004 report, the Secretary of the Department of Veterans Affairs indicated that patient populations served in state veterans' nursing homes are relatively similar nationwide and that patients receive predominantly long-stay nursing home care.[5] Comprehensive information on state veterans' nursing home populations would enable VA to develop a baseline for tracking changes in the veteran populations and

[3]See GAO, *VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps*, GAO-05-65 (Washington, D.C.: Nov. 10, 2004).

[4]In November 1999, the Congress passed the Veterans Millennium Health Care and Benefits Act, Pub. L. No 106-117, 113 Stat. 1545, which required VA to provide nursing home care to veterans requiring such care with a service-connected disability rated at 70 percent or greater, those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent of greater, and those who were receiving care in VA nursing homes on the enactment date of the act and continue to need that care. For all other veterans in VA's nursing home program who are not covered under the act, VA provides care on a discretionary basis. In our 2004 report, we found that about three-quarters of veterans in VA-operated nursing homes received such care on a discretionary basis.

[5]See GAO-05-65.

care provided in this setting. Such information—along with comparable information from VA nursing homes and for veterans for whom VA purchases services in privately owned nursing homes—would allow VA to strategically plan how to best use the three settings of its nursing home program to meet the needs of veterans. Moreover, when used in conjunction with forecasts of the likely demand for VA's nursing home care in the future, such data could allow VA to make informed policy decisions about which groups of veterans VA will serve in the future and therefore the extent to which VA will need to provide long and short-stay nursing home care. Such decisions are important because most veterans who need nursing home care do not receive it from VA, but instead receive it from non-VA providers primarily funded by Medicare and Medicaid. Although VA is in the process of developing its strategic plan for nursing home care, it has not finalized its strategic plan for its long-term care services, which includes nursing home care.[6]

Comprehensive data on the veterans served in state veterans' nursing homes could also help VA assess the impact of proposed changes to its per diem reimbursements for state veterans' nursing homes. The President's 2006 budget request for VA contained a proposal to change per diem reimbursement to take into account veterans' VA priority group status[7] and the type of nursing home care veterans need. You have expressed concern over the potential impact of these changes on the veterans receiving care in state veterans' nursing homes. Comprehensive information on the veteran populations served in state veterans' nursing homes—including the number of veterans in this setting in each of VA's priority groups—could help VA and the Congress by providing better information to assess the impact of such proposed policy changes.

[6]See GAO, *VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans*, GAO-06-333T (Washington, D.C.: Jan. 9, 2006) and GAO, *VA Health Care: Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care*, GAO-05-429 (Washington, D.C.: Aug. 5, 2005) for a discussion of VA's challenge in completing a strategic plan for long-term care services.

[7]VA assigns veterans who have enrolled for VA hospital and outpatient medical services to one of eight priority groups. Priority is generally determined by a veteran's degree of service-connected or other disability or on financial need. VA gives veterans in Priority Group 1 (50 percent or more service-connected disabled) the highest preference for services and gives lowest preference to those in Priority Group 8 (no disability, with income exceeding VA guidelines, and who were enrolled as of January 16, 2003). Veterans who met the criteria for Priority Group 8 and applied for enrollment on or after January 17, 2003, are considered "new" Priority Group 8 veterans and are not eligible for VA hospital and outpatient medical services. Enrollment is not required to receive nursing home care in any of VA's three nursing home settings.

You requested that we provide information on state veterans' nursing homes and the extent to which VA collects information on veterans and the type of care they receive in this setting. During the course of our work, we also found inconsistencies in certain practices related to VA's per diem reimbursements to state veterans' nursing homes. In this report, we (1) describe the extent to which key admission criteria for state veterans' nursing homes in selected states differ, (2) describe the extent to which state veterans' nursing homes in the selected states rely on VA and non-VA sources of revenue, (3) examine whether VA compiles information on state veterans' nursing home populations needed for VA's strategic planning of its nursing home care, and (4) assess whether VA's per diem reimbursement policy has been applied consistently.

To perform our work, we collected information on state veterans' nursing homes primarily from four states—Florida, Maine, Oklahoma, and Pennsylvania—and supplemented this information with data from national sources. We selected these four states based on geographic region, population density, plans to expand the number of state veterans' nursing homes, and whether the state veterans' nursing homes in these states receive Medicare and Medicaid reimbursements. We used a data collection instrument to obtain data from each of the four states on all of their state veterans' nursing homes and reviewed VA and state veterans' nursing home documents. In the four states we conducted site visits to a total of nine state veterans' nursing homes: two of Florida's five state veterans' nursing homes, two of Maine's five homes, three of Oklahoma's seven homes, and two of Pennsylvania's six homes. We interviewed state veterans' nursing home program officials, the administrators of the nine state veterans' nursing homes we visited, officials at VA headquarters, and staff at six VA medical centers of jurisdiction. Staff from VA medical centers of jurisdiction oversee the state veterans' nursing homes in their geographic areas through annual on-site inspections and through reviewing and approving requests from these homes for per diem reimbursements. To identify the characteristics of veteran nursing home populations needed for VA's strategic planning, we identified several of the key characteristics of nursing home populations that are useful for long-term care planning and collected data on these characteristics from state veterans' nursing home patient populations in the selected states. During the course of our work—in interviews with staff of VA medical centers of jurisdiction, state veterans nursing home officials, and VA headquarters staff—we found inconsistencies in certain practices related to VA's per diem reimbursements. These practices involved determining which veterans can be counted for per diem reimbursements. To examine these issues further, we reviewed VA's policy and guidance for overseeing state

veterans' nursing home operations. To identify states that have state veterans' nursing homes certified for Medicare or Medicaid reimbursement we also used data from the Centers for Medicare & Medicaid Services (CMS) Nursing Home Compare national database. For additional information on VA's national per diem and construction grant programs, we interviewed VA headquarters staff who administer these programs. We also reviewed our previous reports on VA long-term care as well as those related to strategic planning (see Related GAO Products at the end of this report). We took steps to ensure that data we obtained from selected state veterans' nursing homes were sufficiently reliable for our purposes. For example, we verified the accuracy of state veterans' nursing home programs' data for internal consistency and compared this information with available VA national data as well as information we obtained through interviews with officials and visits to the selected states. Because we limited our review to four states, the results are not generalizable to other states with state veterans' nursing homes. We performed our work from December 2004 through March 2006 in accordance with generally accepted government auditing standards. For additional details of our scope and methodology, see appendix I.

Results in Brief

Criteria for granting admission to state veterans' nursing homes differ in two key respects, because states have the flexibility to establish their own admission criteria. Florida, Maine, and Pennsylvania admit both wartime and peacetime veterans. In contrast, Oklahoma admits wartime veterans only. Maine and Pennsylvania admit both veterans and certain nonveterans, such as widows of veterans or parents of veterans who died in the line of military duty. In contrast, Florida and Oklahoma admit veterans only. The selected states also have some key admission criteria in common. Each state requires veterans to have been discharged from the military under honorable conditions and requires all patients to be certified by a physician as having a medical basis for admission to a nursing home.

State veterans' nursing homes in the four selected states rely on VA and non-VA sources of revenue to varying degrees. In each of these states, VA's per diem reimbursements accounted for about one-fourth to one-third of state veterans' nursing home revenues used for veterans' care in fiscal year 2004. VA reimburses state veterans' nursing homes for services provided to eligible veterans—in general, those who were discharged from military service under conditions other than dishonorable and who have been determined by a physician as requiring nursing home care. In addition to revenues from VA, state veterans' nursing homes in two of the four

selected states—Florida and Maine—receive reimbursement from Medicare and Medicaid for the inpatient nursing home care they provided to veterans. Additionally, state veterans' nursing homes in three of the four selected states—Pennsylvania, Oklahoma, and Florida—receive funds directly from their states for veterans' care. In fiscal year 2004, this source accounted for 54 percent of the revenues used to provide care to veterans in Pennsylvania, 32 percent in Oklahoma, and 10 percent in Florida.

VA does not compile the information it needs for strategic planning on several key characteristics of the veteran populations receiving care in state veterans' nursing homes: veterans' length of stay, VA priority group status, age, and gender. VA does not have information, for example, on the extent to which veterans in state veterans' nursing homes receive long and short-stay care. Patients' length of stay is a predictor of the amount and type of medical resources devoted to their care. VA officials have assumed that state veterans' nursing homes predominantly provide long-stay care, but our review of selected states and national data suggests that this may not always be the case. VA concurred in principle with our 2004 recommendation to collect data on veterans' lengths of stay in state veterans' nursing homes nationwide, and the agency informed us in 2005 that it will report these data to its policymakers and planners in fiscal year 2007. In our visits to selected states, we found that state veterans' nursing homes in Pennsylvania, Oklahoma, and Florida generally provide long-stay care. In contrast, we found that 60 percent of the stays in Maine state veterans' nursing homes are short. VA also does not compile information it needs on the VA priority group status of veterans admitted to state veterans' nursing homes. The availability of priority group status information may differ among the states. Veterans in state veterans' nursing homes who have previously enrolled for VA hospital and outpatient medical services will have been assigned to a priority group. However, veterans in state veterans' nursing homes who have not enrolled will not have been assigned a priority group. The extent to which veterans without a priority group designation enroll with VA upon admission to state veterans' nursing homes may vary because not all states require veterans to enroll for VA hospital and outpatient medical services.

During the course of our work, we found that certain aspects of VA's per diem reimbursement policy had not been applied consistently. For example, staff from a VA medical center of jurisdiction told us that they approved reimbursements to state veterans' nursing homes only for care provided to veterans whose military service occurred during VA-designated periods of military conflict (wartime veterans). However, VA's policy does not limit per diem reimbursements to such veterans. We also

found that VA headquarters officials have provided inconsistent instructions on VA's reimbursement policy. Specifically, staff at a VA medical center of jurisdiction were told by a VA headquarters official that they could not approve per diem reimbursements to state veterans' nursing homes for care provided to new Priority Group 8 veterans, but were told by a different headquarters official that they could approve such care. Lacking clear guidance on whether they should approve reimbursement for services provided to new Priority Group 8 veterans admitted to state veterans' nursing homes, the medical center staff decided to approve such reimbursements.

To help ensure that VA can conduct adequate strategic planning for its nursing home care and strengthen its administration and oversight, we are recommending that VA compile and report data on the age and gender of veterans admitted to state veterans' nursing homes, compile available data on the priority group status of veterans in state veterans' nursing homes, and explore with these nursing homes options for estimating the number of unenrolled veterans in each priority group, clarify that VA policy allows state veterans' nursing homes to receive reimbursement for both wartime and peacetime veterans, and clarify whether VA policy allows reimbursement for new Priority Group 8 veterans.

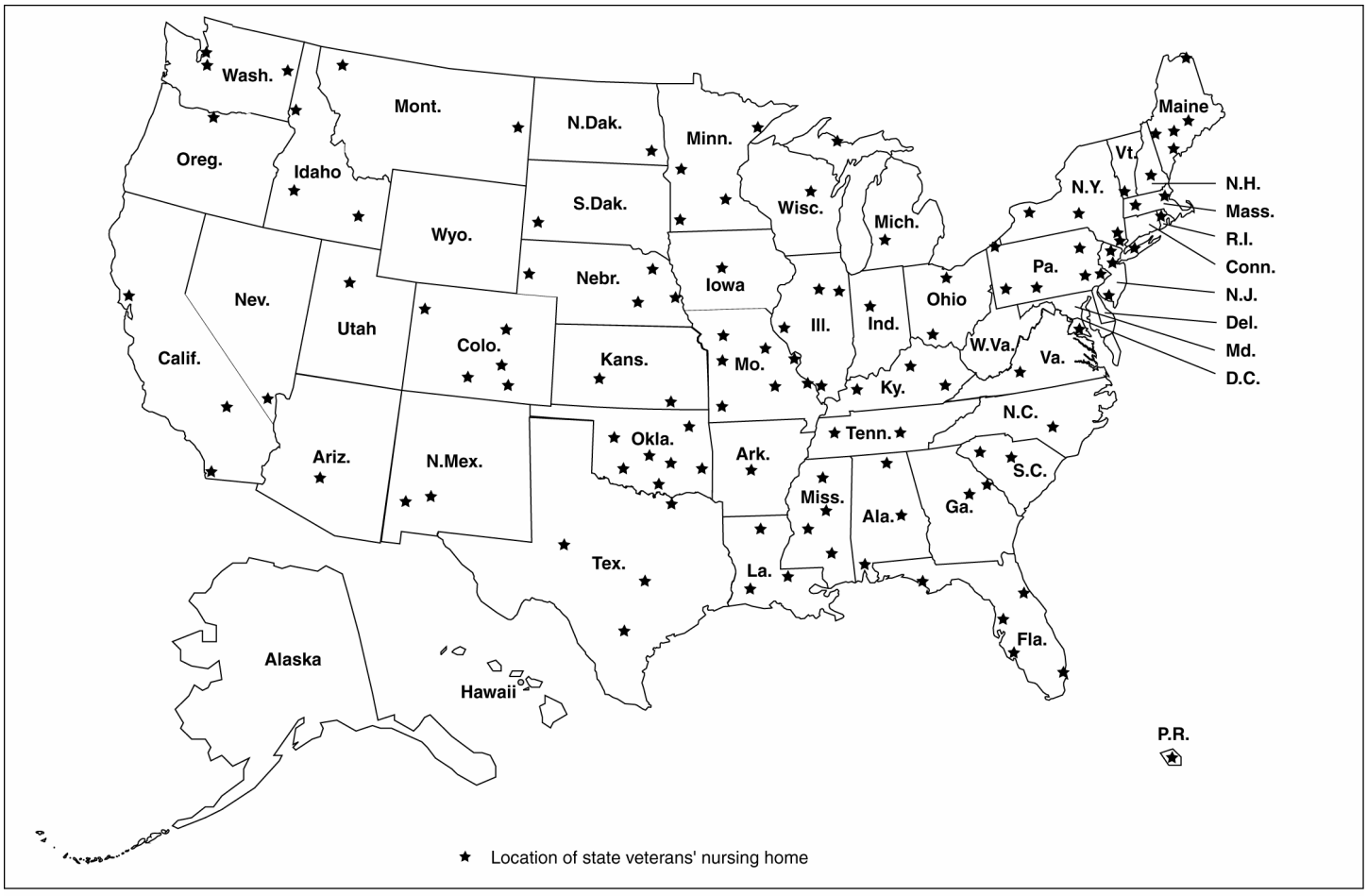
VA stated that it agreed with our overall findings and generally concurred with our recommendations. VA stated that it plans to collect demographic information on state veterans' nursing home patients on a more structured, routine basis. VA indicated that the collection of state veterans' nursing home demographic information on a more structured, routine basis requires the development of new software, which VA anticipates might be completed by the end of fiscal year 2007. VA agreed with our recommendations to clarify reimbursement policy on the state veterans' nursing homes and stated that it plans to do so by issuing a national information letter to VA medical centers of jurisdiction by the end of fiscal year 2006.

Background

VA provides or pays for nursing home care for veterans in three settings. VA reports that it operates 134 nursing homes of its own, which in fiscal year 2005 accounted for about 35 percent of VA's nursing home care workload. Almost all of these nursing homes are attached or in close proximity to a VA medical center. VA also contracts for care of veterans in over 2,000 VA-approved, privately owned nursing homes located in communities across the country. In fiscal year 2005, these homes provided services to nearly 13 percent of VA's nursing home workload. In fiscal year

2005, about 52 percent of VA's nursing home workload was provided in a third setting—state veterans' nursing homes located in 44 states and Puerto Rico (see fig. 1).[8]

Figure 1: State Veterans' Nursing Home Locations, Fiscal Year 2005

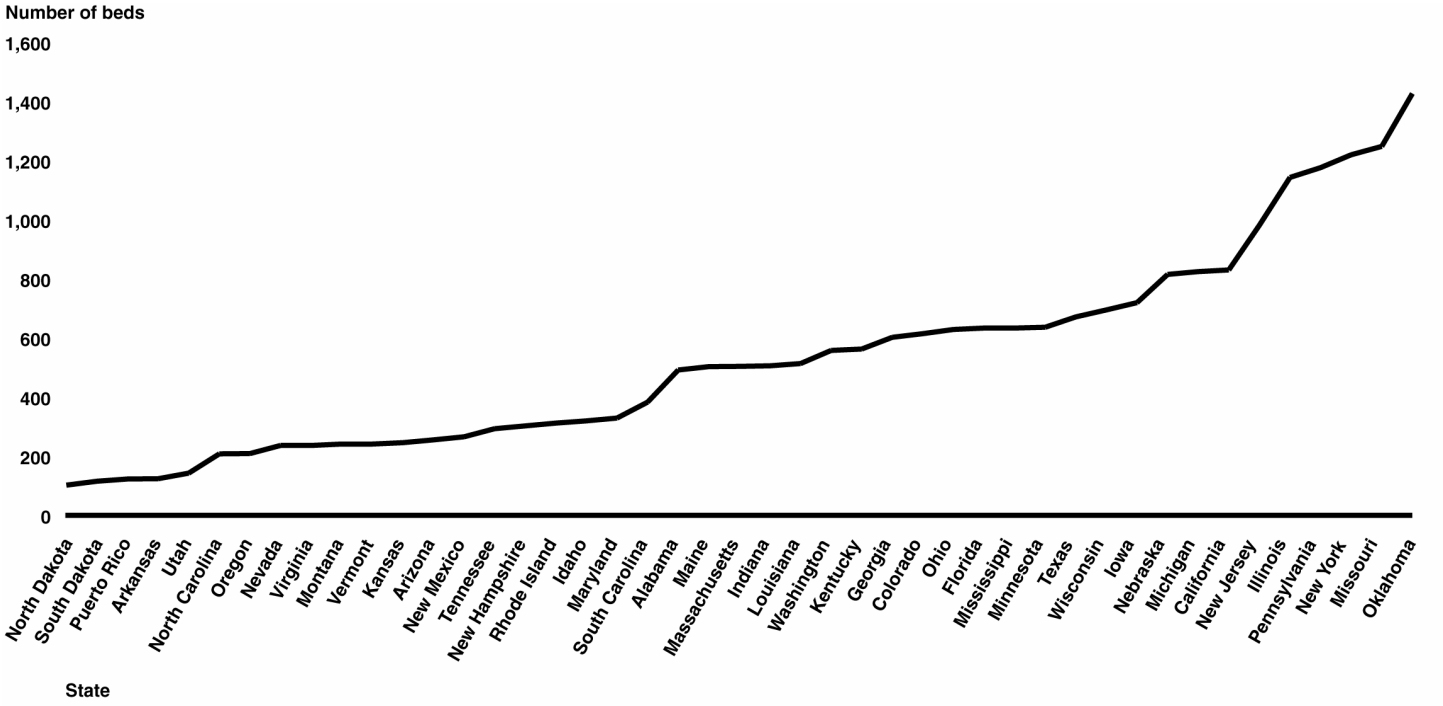


Source: VA, CMS, and State Veterans' Nursing Home programs.

[8]As of fiscal year 2005, six states—Alaska, Connecticut, Delaware, Hawaii, West Virginia, and Wyoming—and the District of Columbia did not operate state veterans' nursing homes. Three of these states—Connecticut, Delaware, and Hawaii—plan to construct their first state veterans' nursing homes. Alaska, West Virginia, and Wyoming operate state veterans' domiciliaries only. Domiciliaries are facilities that care for veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities.

Across the country, there is wide variation in the capacity of state veterans' nursing home programs, as determined by the number of beds in state veterans' nursing homes. For example, in the 44 states and Puerto Rico that operate state veterans' nursing homes, the number of state veterans' nursing home beds ranged from 38 in North Dakota to 1,439 in Oklahoma in fiscal year 2005 (see fig. 2).

Figure 2: Number of State Veterans' Nursing Home Beds, Fiscal Year 2005



Source: VA.

State veterans' nursing homes provide long and short-stay care. Generally, long-stay care involves care of 90 days or more needed by veterans who cannot be cared for at home because of severe, chronic physical or mental limitations. Such care includes assistance with activities of daily living.[9] Short-stay care typically involves care of less than 90 days and includes

[9]Activities of daily living are tasks relating to independent living and personal care, such as feeding oneself, bathing, toileting, dressing, and getting in and out of bed or a chair.

skilled nursing services for rehabilitative care following hospitalization or serious illness.

VA funds state veterans' nursing homes through per diem reimbursements that cover a portion of the costs of the nursing home care provided to veterans. In fiscal year 2005, VA paid $382 million in per diem payments for patient care. VA annually adjusts its per diem reimbursement rate for all state veterans' nursing homes, which in fiscal year 2005 was $59.36 per veteran. As part of VA's support and oversight of state veterans' nursing homes, VA medical centers of jurisdiction process and approve per diem reimbursements for the state veterans' nursing homes located in their geographic areas.[10] In addition to paying for a portion of the cost of providing nursing home care to veterans, VA supports state veterans' nursing homes through grants for construction, acquisition,[11] or renovation of existing structures. VA provides grants to states for nursing home construction, acquisition, or renovation following its review and approval of proposals submitted by state officials.[12] In fiscal year 2005, VA spent over $123 million for construction or renovation projects.[13] VA requires states with state veterans' nursing homes that were constructed, acquired, or renovated with VA construction grants to operate these homes as state veterans' nursing homes for a period of 20 years.

In addition to per diem payments and construction grants from VA, state veterans' nursing homes may receive payments from a number of different sources, including Medicare and Medicaid. CMS, an agency within the U.S. Department of Health and Human Services, certifies that nursing homes—including state veterans' nursing homes—are qualified to receive Medicare

[10]In states with multiple VA medical centers of jurisdiction, such centers may oversee one or more state veterans' nursing homes; other states may have a single VA medical center of jurisdiction overseeing one or more state veterans' nursing homes.

[11]Acquisition refers to the purchase of a facility for the purpose of operating it as a state veterans' nursing home. No state has requested a grant from VA for this purpose.

[12]If a state veterans' home was constructed or renovated with a grant from VA, at least 75 percent of that nursing home's residents must be eligible veterans in order for the home to receive VA per diem reimbursements. If the state veterans' nursing home did not receive a construction grant from VA, VA requires that more than 50 percent of the residents be eligible veterans in order for the home to receive VA per diem reimbursements. See 38 CFR § 51.210(d)(2005).

[13]Because some states have nursing home and domiciliary facilities in the same location, some VA grants are for projects to improve facilities that provide both veterans' nursing home care and domiciliary services.

and Medicaid reimbursement.[14] For state veterans' nursing homes that are certified to receive Medicaid reimbursement, the state's Medicaid funding may be one source of a state's support for its state veterans' nursing homes.[15]

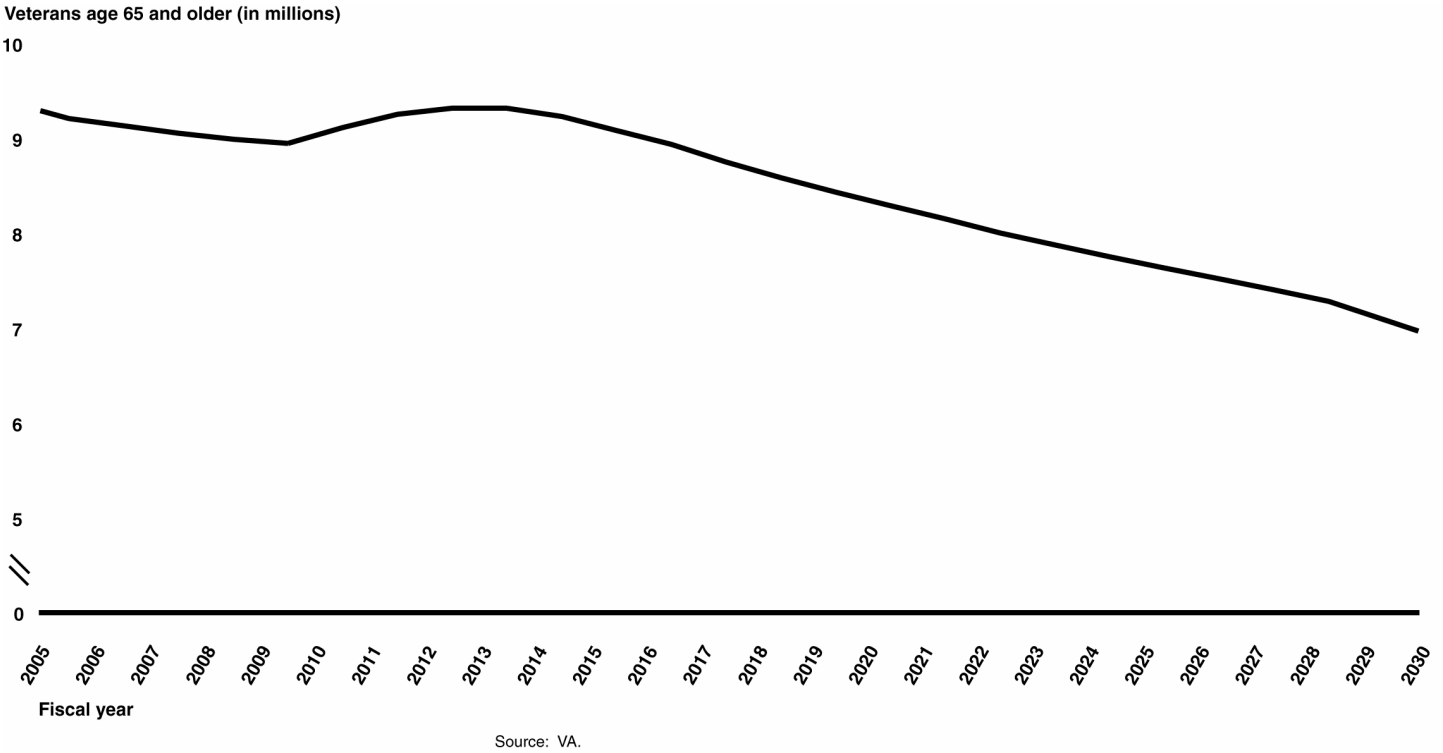
Medicare and Medicaid typically reimburse state veterans' nursing homes for different types of nursing home care provided to veterans. Medicare primarily covers costs for acute health care services, and, therefore, limits its nursing home coverage to short stays requiring skilled nursing care following hospitalization. In contrast, Medicaid programs provide coverage for long-stay nursing home care for patients who require assistance with activities of daily living, such as eating and bathing. Although VA is not authorized in most cases to bill and collect payments from Medicare and Medicaid, state veterans' nursing homes are not prohibited from doing so. As a result, in addition to per diem reimbursement from VA, state veterans' nursing homes may receive reimbursement from other sources such as Medicare or Medicaid for care provided to an individual veteran.

The number of veterans aged 65 and older is expected to decrease after 2013 through 2030 (see fig. 3). From 2005 to 2013, the number of these veterans first declines then increases until 2013, in part, because of the aging of Vietnam-era veterans. In contrast, the number of persons aged 65 and older in the general population is expected to increase steadily from 2005 through 2030.

[14]Medicare is the federal health insurance program that serves the nation's elderly and disabled. Medicare covers skilled nursing services for stays lasting up to 100 days, per spell of illness. Medicaid is the joint federal-state health care financing program that covers basic health and long-term care services for certain low-income individuals.

[15]Medicaid funding is derived from a combination of funds contributed by the state and the federal government. The federal government provides funds to match a percentage of a state's Medicaid expenditures. The amount of federal matching funds is determined by a formula that provides a higher federal matching rate for states with lower per capita incomes.

Figure 3: Projected Veteran Population Age 65 and Older, Fiscal Year 2005 through Fiscal Year 2030



Source: VA.

VA has recognized the importance of accounting for demographic changes in the veteran population and strategically planning the future delivery of nursing home care to veterans. In May 2004, in an announcement of realignment decisions resulting from VA's Capital Asset Realignment for Enhanced Services (CARES) process,[16] the Secretary of Veterans Affairs identified the need for VA to plan to meet the needs of an aging veteran population. In his CARES announcement, the Secretary noted that VA was in the process of developing a strategic plan for long-term care, including nursing home services. A strategic plan for long-term care would, for

[16]VA initiated the CARES process in response to our recommendations in 1999 for improving the department's capital asset planning and budgeting (see GAO, *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting*, GAO/HEHS-99-145 (Washington, D.C.: Aug. 13, 1999)). The CARES process identified what health care services VA should provide in which locations through fiscal year 2022. CARES resulted in decisions to realign inpatient services at some VA facilities and to leave services as currently aligned at others.

instance, incorporate forecasts of the likely demand for VA's nursing home care, help determine which veterans VA will serve—as a matter of policy—among those seeking nursing home care from VA, and help determine the extent to which VA should provide long and short-stay nursing home care to the veterans it has chosen to serve.

Selected States Have Admission Criteria That Differ in Two Key Respects

The selected states we reviewed have criteria for granting admission to their state veterans' nursing homes that differ in two key respects. States have the flexibility to establish their own admission criteria because VA does not control the admission process or specify the admission criteria that states should use. The selected states differ in whether their state veterans' nursing homes admit peacetime veterans. Florida, Maine, and Pennsylvania admit both wartime and peacetime veterans. In contrast, Oklahoma admits wartime veterans only. The selected states also differ in that some admit certain nonveterans. Maine and Pennsylvania admit certain nonveterans—such as widows of veterans or parents of veterans who died in the line of military duty. In contrast, Florida and Oklahoma admit veterans only (see table 1).

Table 1: Veteran and Nonveteran Workload (Average Daily Census) in State Veterans' Nursing Homes, Fiscal Year 2004

	Florida[a]	Maine	Oklahoma	Pennsylvania
Veterans	327	320	1140	947
Nonveterans	0[b]	108	0[b]	87
Total workload	**327**	**428**	**1140**	**1034**

Source: GAO analysis of Florida, Maine, Oklahoma, and Pennsylvania data.

[a]In fiscal year 2004, Florida was in the process of opening two new state veterans' nursing homes; workload at these two homes is not included in this table.

[b]Florida and Oklahoma do not admit nonveteran patients.

The four states we visited all share two other key admission criteria. Each state requires veterans to have been discharged from the military under honorable conditions and requires all patients to be certified by a physician as having a medical basis for admission to a nursing home. In the selected states, this latter requirement is met if a physician certifies that the patient either requires some form of skilled nursing care or needs assistance with activities of daily living. For example, patients in Maine's state veterans' nursing homes must be certified by a physician as requiring skilled nursing care or assistance with at least three such activities of daily living. Similarly, Pennsylvania admits patients to its state veterans' nursing

homes if they have been certified as needing skilled nursing care or assistance with activities of daily living. In Florida, admission to a state veterans' nursing home requires that a VA physician certify that the patient requires nursing home care. In Oklahoma, a physician from a state veterans' nursing home must conduct a physical exam and certify that any veteran admitted to a state veterans' nursing home is disabled or diseased to a degree that requires nursing home care.

State Veterans' Nursing Homes in Selected States Vary in the Extent to Which They Rely on Revenue from VA and Other Sources

State veterans' nursing homes in the four states we visited rely, to varying degrees, on VA and non-VA sources of revenue. (See table 2 for a summary of the sources of revenue used for veterans' care in state veterans' nursing homes in the four selected states.) In fiscal year 2004 about one-fourth to one-third of the revenue used by these nursing homes for veterans' care[17] came from VA per diem reimbursements. This source accounted for 34 percent of revenues used to provide care to veterans in Oklahoma, 29 percent in Florida, 24 percent in Maine, and 22 percent in Pennsylvania. VA reimburses state veterans' nursing homes for services provided to eligible veterans—those who were discharged from military service under conditions other than dishonorable and who have been determined by a physician as requiring nursing home care. VA, however, does not provide per diem reimbursement for services provided to nonveterans admitted to a state veterans' nursing home—such as a veteran's spouse or parent of a veteran killed in the line of military duty.

[17]In this report, state veterans' nursing home revenue used for patient care does not include grants from VA for construction, acquisition, and renovation.

Table 2: Sources and Percentage of State Veterans' Nursing Home Revenues Used for Veterans' Care, Fiscal Year 2004

Sources of revenue for veterans' care	Oklahoma	Florida	Maine	Pennsylvania
VA per diem	34%	29%	24%	22%
Self-payment and other sources[a]	33%	30%	25%	23%
State funds	32%	10%	0	54%
Medicaid[b]	0[c]	22%	37%	0[c]
Medicare, Parts A & B	0[c]	9%[d]	15%[e]	<1% [c, e]

Source: GAO analysis of Florida, Maine, Oklahoma, and Pennsylvania data.

Notes: This table does not include revenues received for nonveteran nursing home residents in Maine and Pennsylvania. In addition, funds obtained from VA construction, acquisition, or renovation grants are not included.

[a]May include revenue sources such as Social Security, pensions, and private insurance.

[b]Includes funds provided by states through their Medicaid programs.

[c]Has not applied for CMS certification for Medicaid or Medicare Part A reimbursement.

[d]Totals for Medicare Part A and Part B could not be separately identified.

[e]Medicare Part B was a small portion of revenue in Maine and Pennsylvania, representing less than 1 percent in each state. Medicare revenue in Pennsylvania is from Medicare Part B only.

Another important source of revenue for the state veterans' nursing homes in the selected states is revenue obtained from patients paying for their nursing home care. These payments come from a patient's own resources, such as Social Security, pensions, and private insurance. In fiscal year 2004 self-payment on the part of patients accounted for 33 percent of patient care revenues in Oklahoma, 30 percent in Florida, 25 percent in Maine, and 23 percent in Pennsylvania. In addition, some state veterans' nursing homes receive funds directly from their states for veterans' care. In the states we visited, Oklahoma, Pennsylvania, and Florida state veterans' nursing homes receive such funds.

Two other sources of revenue for some state veterans' nursing home programs are reimbursements from Medicare and Medicaid. State veterans' nursing homes may receive funding concurrently from VA, Medicaid, and Medicare for the costs of providing services to an individual veteran. State veterans' nursing homes in two of the selected states—Florida and Maine—are certified to receive Medicaid or Medicare Part A

reimbursement for inpatient services.[18] Additionally, Medicare Part B is another source of revenue for some state veterans' nursing homes, but represents a small portion of revenue.[19] In fiscal year 2004, Florida's state veterans' nursing homes relied on Medicaid for 22 percent of revenue and Medicare Parts A and B for 9 percent of their revenue for veterans' care. In that same year, Maine's state veterans' nursing homes relied on Medicaid for 37 percent of their veterans' care revenue and Medicare Parts A and B for about 15 percent of such revenue. State veterans' nursing homes in Oklahoma and Pennsylvania have not applied for CMS certification and therefore do not receive reimbursement from Medicaid or Medicare Part A for inpatient services. Medicare Part B payments represent a small portion of revenue for Pennsylvania state veterans' nursing homes. However, Oklahoma state veterans' nursing home officials do not consider Medicare Part B payments to be revenue because such payments are made directly to private contractors who provide services such as physical or speech therapies.

In addition to revenues used for veterans' care, the four states we visited also have received revenue in the form of grants from VA that pay up to 65 percent of the cost of constructing new state veterans' nursing homes or renovating existing homes. Using VA construction grants, Florida has expanded the number of its state veterans' nursing homes from one location to five since 1993. Oklahoma operates a total of seven state veterans' nursing homes, having recently constructed a new home in Lawton in 2003. Pennsylvania opened a new state veterans' nursing home in Philadelphia in 2003, increasing the number of its homes to six. Many of the state veterans' nursing homes in Oklahoma and Pennsylvania are old—the Ardmore, Oklahoma home opened in 1910 as a home for civil war veterans and the Pennsylvania Soldiers and Sailors Home, in Erie, opened in 1886. Both states have used VA renovation grants to upgrade existing state veterans' nursing homes and plan to use such grants to improve others. Similarly, Maine has expanded three of its five state veterans'

[18]To receive Medicaid or Medicare Part A reimbursement, nursing homes, including state veterans' nursing homes, must be certified by CMS. Medicaid coverage of nursing home services varies from state to state and may include reimbursement for services such as basic custodial care, medical social services, and rehabilitative therapies. Medicare Part A provides payment for skilled nursing facility, inpatient hospital, hospice, and certain home health services.

[19]Medicare Part B provides payment for physician services, diagnostic tests, related services and supplies, and medical equipment. Nursing homes do not need CMS certification to receive reimbursement under Medicare Part B.

nursing homes since 2002. Since 1964, VA has contributed to the construction or renovation of homes in each of the 44 states and Puerto Rico that operate state veterans' nursing homes and has approved grants to the 3 states that plan to construct their first homes. VA has provided approximately $607 million in grants for the construction and renovation of state veterans' homes since 1999.

State veterans' nursing home officials in two of the states we visited were cautious in making plans to construct new veterans' nursing homes, while officials in the two other states were planning no new construction. Officials in all four states explained that while veterans' need for nursing home care is increasing, the projected decrease after 2013 in the number of veterans over age 65 and continued expansion of state veterans' nursing homes could lead to excess nursing home capacity. Florida officials told us that VA's requirement that states agree to operate state veterans' nursing homes for 20 years if using a VA construction grant creates a substantial financial commitment. As a result, these officials stated that they were likely to limit their request for VA construction grants to 5 new nursing homes, although VA's nursing home capacity projections would allow Florida to request grants for as many as 31 new state veterans' nursing homes. Similarly, Pennsylvania state veterans' nursing home officials told us that they were weighing the benefits associated with constructing new homes against the long-term costs of their operation. Pennsylvania officials told us they were considering constructing only one new nursing home. Also, officials from Maine and Oklahoma state veterans' nursing homes stated that they have no plans to expand the number of state veterans' nursing homes in their states. According to a VA program official, most states have completed constructing nursing homes and now have a greater need for VA grants to renovate existing nursing homes. As a result, the focus of VA's construction grant program has shifted away from constructing new state veterans' nursing homes toward renovating existing nursing homes. This official anticipates that only states with large veteran populations, such as Florida and California, will construct new state veterans' nursing homes.

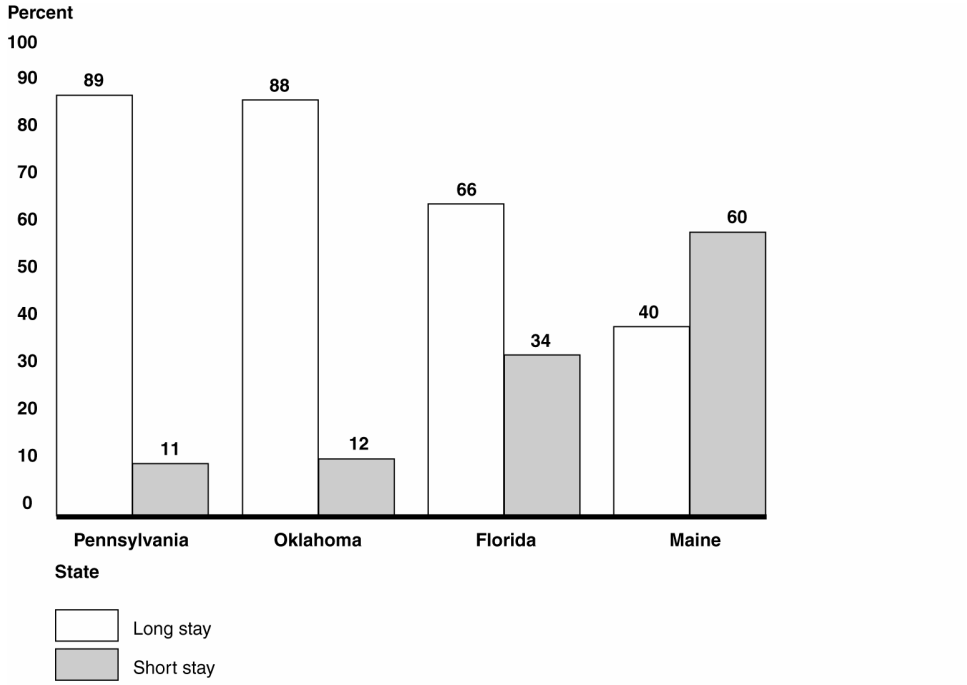
VA Does Not Compile Information on State Veterans' Nursing Home Populations Needed for Strategic Planning

VA does not compile the information it needs on several key characteristics of the veteran populations receiving care in state veterans' nursing homes: veterans' length of stay, VA priority group status, age, and gender. Without this information, VA cannot develop baseline data of characteristics of veterans in state veterans' nursing homes and the care provided to them, which can help VA estimate the proportion of nursing home need it currently meets and the need it may be asked to meet as the number of older veterans changes over time. These estimates can help VA plan the delivery of nursing home care across its three nursing home settings. Based on our visits to four states, we obtained information on key characteristics of state veterans' nursing home populations, which showed that these populations differed to varying degrees across the states.

VA does not have the information it needs on the extent to which veterans in state veterans' nursing homes receive long-stay care (90 days or more) and short-stay care (less than 90 days). Patients' length of stay is a predictor of the amount and type of medical resources devoted to their care. For example, short-stay care often requires skilled nursing services for recovery from surgery such as hip replacement, or from serious illnesses such as a stroke. Long-stay care typically involves less intense nursing care for daily assistance with personal care tasks. Having information on the length of stays across state veterans' nursing homes would help VA in tracking the medical resources used across its three nursing home settings, thereby enabling VA to more accurately forecast the amount of medical resources needed in the future. VA concurred in principle with our 2004 recommendation that it collect and make available to VA policymakers and planners data on the number of veterans who have long and short stays in state veterans' nursing homes nationwide. VA informed us in 2005 that it will report these data in fiscal year 2007.

From our visits to selected states, we obtained information on the extent to which veterans in state veterans' nursing homes received long and short-stay care. The state veterans' nursing homes in these four states varied widely in terms of the lengths of their veterans' stays (see fig. 4).

Figure 4: Percentage of Veterans' Nursing Home Stays That Were Long Stay (90 Days or More) and Short Stay (Less Than 90 days), Fiscal Year 2004



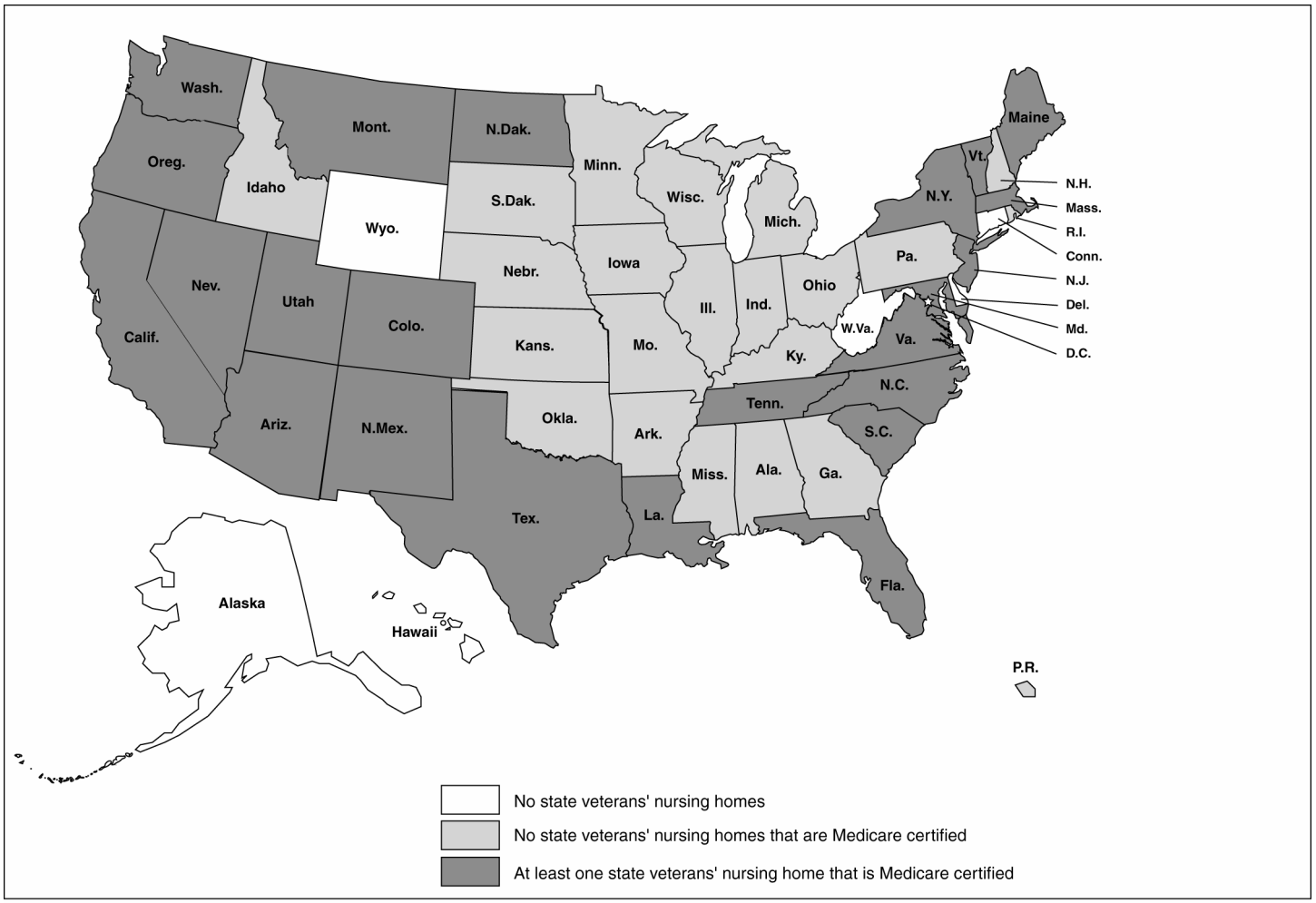
Source: GAO analysis of Florida, Maine, Oklahoma, and Pennsylvania data.

Three of the four states—Florida, Oklahoma, and Pennsylvania—generally provide what may be considered more traditional nursing home services—predominantly long-stay, chronic care for individuals who require 24-hour care for activities of daily living. Between 66 and 89 percent of veterans' stays in state veterans' nursing homes in these three states was long stay in duration. State veterans' nursing home officials from these states stated that their nursing homes were structured—in terms of the type of care for which their homes are staffed and equipped—to deliver primarily long-stay services. In contrast, program officials from Maine stated that their state veterans' nursing homes were staffed and equipped to provide both long-stay and short-stay care services. In fiscal year 2004, 60 percent of veterans' stays in Maine state veterans' nursing homes were short stay.

Despite VA officials' assertion that state veterans' nursing homes provide predominantly long-stay care, the amount of short-stay nursing home care provided in Maine raises questions about the extent to which VA's assertion is accurate. Like Maine, state veterans' nursing homes in other

states may be providing significant amounts of short-stay care. As indicated by national CMS data, 23 states, including Maine and Florida, have state veterans' nursing homes that are certified to receive Medicare reimbursement (see fig. 5). Medicare typically reimburses CMS-certified nursing homes for short-stay, postacute services provided to patients enrolled in Medicare. CMS data, along with data we collected in our review, suggest that state veterans' nursing homes in the 23 states may be providing short-stay care to veterans in amounts that may be significant.

Figure 5: States with State Veterans' Nursing Homes Certified for Medicare Reimbursement, Fiscal Year 2005



Source: GAO analysis of CMS data and VA data.

VA also does not compile information it needs on the VA priority group status of veterans admitted to state veterans' nursing homes. VA does not compile this information in its headquarters, and in the four states we visited, neither the VA medical centers of jurisdiction nor the state veterans' nursing homes compile information on veterans' priority group status. VA needs this information to be able to determine which priority groups of veterans it is serving in this setting. This information can help VA in its strategic planning, especially when making policy decisions regarding which veterans to serve in its nursing home program and how many veterans such policies could affect.

The availability of priority group information on veterans in state veterans' nursing homes may vary. Veterans in state veterans' nursing homes who have previously enrolled for VA hospital and outpatient medical services will have been assigned to a priority group. However, veterans in state veterans' nursing homes who have not enrolled will not have been assigned a priority group. The extent to which veterans without a priority group designation enroll with VA upon admission to state veterans' nursing homes may vary because not all states require veterans to enroll. For example, Florida requires veterans to enroll for VA hospital and outpatient medical services as part of the admission process to their state veterans' nursing homes. The other three states encourage—but do not require—enrollment upon admission.

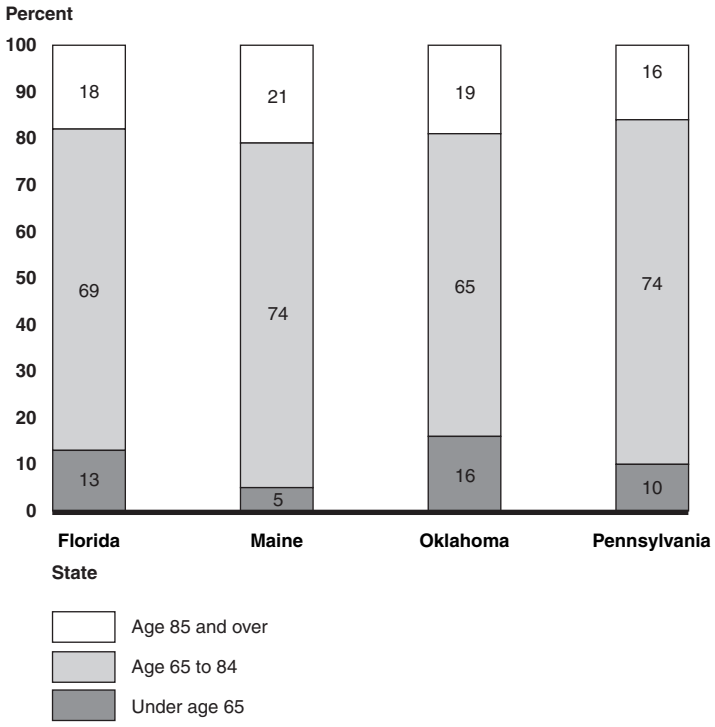
Because VA does not collect information on the priority group status of veterans in state veterans' nursing homes, it cannot, for example, assess the potential impact of proposed changes to per diem reimbursement, such as the proposal contained in VA's 2006 budget submission. VA proposed changing per diem reimbursements to be based on whether a veterans' priority group status is considered high or low.[20] VA proposed reimbursing state veterans' nursing home for long-stay and short-stay care provided to veterans in the higher priority groups. However, the proposal restricted VA reimbursement for services provided to veterans in lower priority groups to short-stay services only. Without information on veterans' priority group status—as well as information on veterans' length of stay—VA is limited in its ability to determine the impact of such policy proposals on veterans and on state veterans' nursing homes.

[20]In its proposal, VA identified as high-priority veterans those assigned to Priority Groups 1 through 3, and those in Priority Group 4 who are catastrophically disabled. VA identified low-priority veterans as those assigned to Priority Group 4 who are not catastrophically disabled and those in Priority Groups 5 through 8.

VA also does not have information it needs on the age of veterans served in state veterans' nursing homes. The likelihood of needing nursing services increases with age; persons aged 65 or older are more likely to need nursing home services. Knowing the number of veterans in this age group that VA is currently serving in state veterans' nursing homes could help VA estimate its market share—that is, the number of veterans aged 65 or older VA is serving in its entire nursing home program, compared to the total number of veterans aged 65 or older nationwide. With this information, VA can track how the proportion of older veterans served by VA's nursing home program changes over time. As a result, VA would be better able to predict—and plan for—changes in the demand for its nursing home care.

The distribution of veterans by age group in state veterans' nursing homes varied somewhat across the selected states, according to our analysis of data obtained from the states (see fig. 6). In all cases across the four selected states, most veterans receiving care in state veterans' nursing homes were in the 65 to 84 age group. Nonetheless, we noted the greatest variation in the proportion of veterans in the group under age 65.

Figure 6: Age Distribution of Veterans in State Veterans' Nursing Homes, Fiscal Year 2004



Source: GAO analysis of Florida, Maine, Oklahoma, and Pennsylvania data.

Finally, VA does not compile the information it needs on the gender of veterans admitted to state veterans' nursing homes. Although VA asks for this information on forms filled out by veterans upon admission to state veterans' nursing homes, it does not routinely analyze or report this information to VA policymakers and planners. Such information can be used as an indicator of the likely need for nursing home services, because females tend to require nursing home services more commonly than males. Therefore, knowing the proportion of females relative to males in the populations served in state veterans' nursing homes—and the degree to which this proportion changes over time—would help VA understand the extent to which it will need to adjust the amount of nursing home services it offers.

Based on information we collected from the states we visited, state veterans' nursing homes in the four states varied somewhat in the extent to which their veteran patients included female veterans, ranging from 3 to

10 percent of all veteran patients. This is generally consistent with the percentage of elderly female veterans in three of the four states. Florida's female veteran population was 10 percent, Maine's 6 percent, Pennsylvania's 4 percent, and Oklahoma's 3 percent.

VA's Per Diem Reimbursement Policy Has Not Been Applied Consistently

During the course of our work, we found that certain aspects of VA's per diem reimbursement policy had not been applied consistently. We found that staff at a VA medical center of jurisdiction were misapplying VA's policy regarding whether peacetime veterans could be counted for reimbursement. In another instance, VA headquarters staff provided inconsistent instructions on whether nursing home services provided to new Priority Group 8 veterans could be approved for reimbursement.

During our visit to Maine, we found that VA staff in Maine misapplied VA's per diem reimbursement policy concerning which veterans may be considered for reimbursements. Specifically, staff from this VA medical center told us that they only approved reimbursement for care provided to veterans admitted to state veterans' nursing homes who have had wartime military service.[21] However, VA's policy does not limit per diem reimbursements to such veterans. The VA medical center staff told us that the wartime limitation had been a long-standing VA policy which had been confirmed by an official in VA's New England Healthcare network.[22] Similarly, Maine's state veterans' nursing home program officials told us that it was their practice to apply to VA for per diem reimbursements on behalf of only those veterans in their nursing homes who had wartime military service. During our visit, we told officials from both the VA medical center of jurisdiction and the state veterans' nursing homes that the practice in Maine of not approving the per diem for peacetime veterans was inconsistent with reimbursement practices of medical centers in other states we visited. These officials later informed us that as of September 2005 Maine state veterans' nursing homes have billed for—and VA will approve reimbursement of—care provided to both wartime and peacetime veterans.

[21]Wartime military service refers to specific VA-designated periods of military conflict, such as World War II, Vietnam War, Korean War, and Gulf War. All other periods of military service are designated as peacetime service.

[22]VA's health care facilities nationwide are organized into 21 regional networks that are structured to manage and allocate resources to VA health care facilities. The New England Healthcare network is one of VA's 21 regional networks.

We also found that VA headquarters officials provided inconsistent instructions on VA's reimbursement policy. According to staff at a VA medical center of jurisdiction in Pennsylvania, VA headquarters officials have not been consistent in explaining whether VA medical centers of jurisdiction could approve per diem reimbursements for nursing home care provided to new Priority Group 8 veterans. Staff at this medical center sought guidance from VA headquarters regarding approval of reimbursement for new Priority Group 8 veterans in state veterans' nursing homes after VA announced that new Priority Group 8 veterans would not be eligible for VA hospital and outpatient medical services as of January 17, 2003. The medical center staff told us that an official at VA headquarters advised them that such reimbursements were appropriate, but that on another occasion a different VA headquarters official advised them that state veterans' nursing homes could not be reimbursed for care provided to new Priority Group 8 veterans. Lacking clear guidance on whether this policy applied to new Priority Group 8 veterans admitted to state veterans' nursing homes, the Pennsylvania VA medical center staff decided to approve reimbursement for nursing home services provided to these veterans.

Conclusions

With state veterans' nursing homes now accounting for over half of VA's nursing home workload, it is especially important that VA have comprehensive information on the veterans being served and the care provided in this setting. VA needs this information to develop a baseline of these data in order to track changes in these variables over time, as part of VA's strategic planning process. A strategic plan, in turn, would help VA determine which veterans it will serve and the type of care to provide across the three settings of its nursing home program as a matter of policy. In addition, VA will be better able to identify the locations where it should or should not invest in the construction, acquisition, or renovation of state veterans' nursing homes to best meet the needs of veterans.

VA does not compile the comprehensive information it needs on veterans in state veterans' nursing homes. In response to our 2004 recommendation, VA has stated that it will report data on the number of veterans who have long and short stays in state veterans' nursing homes nationwide in fiscal year 2007. However, VA does not compile other information it needs on veterans in state veterans' nursing homes nationwide—information on veterans' gender, age, and priority group status. The availability of priority group information may differ depending on the extent to which states require or encourage veterans to enroll for VA hospital and outpatient medical services. VA can compile available information on veterans'

priority group status for those veterans who have enrolled. Without comprehensive information on veterans in this setting, VA cannot determine, for example, how many veterans may be affected by proposals to change which veterans will be served through VA's per diem reimbursements. Lacking comprehensive information on veterans served and the care delivered in state veterans' nursing homes, VA officials have assumed that the patient populations served in state veterans' nursing homes are relatively similar nationwide and that this setting provides predominantly long-stay nursing home care. The fact that we found—contrary to these assumptions—differences in the veteran populations served by state veterans' nursing homes, as well as in veterans' lengths of stay, underscores the importance of VA compiling national data on state veterans' nursing homes.

In addition, we found that VA's oversight of its per diem reimbursements could be strengthened. VA needs to ensure that state veteran nursing home programs are consistent in their billing practices and that VA is paying appropriately to support the nursing home care veterans receive in state veterans' nursing homes. However, in our visits to selected states we found inconsistencies in the application of VA's per diem reimbursement policy, which have generated uncertainty over which veterans may be included in per diem reimbursement calculations.

Recommendations for Executive Action

To help ensure that VA can conduct adequate strategic planning for nursing home care and strengthen its administration and oversight of the state veterans' nursing homes, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following four actions:

- compile and report data on the age and gender of veterans admitted to state veterans' nursing homes;
- compile available data on the priority group status of veterans in state veterans' nursing homes, and explore with these nursing homes options for estimating the number of unenrolled veterans in each priority group;
- clarify that state veterans' nursing homes may receive reimbursement from VA for services provided to veterans who have either wartime or peacetime military service; and
- clarify VA policy regarding whether state veterans' nursing homes may receive reimbursement from VA for nursing home services provided to new Priority Group 8 veterans admitted to state veterans' nursing homes.

Agency Comments and Our Evaluation

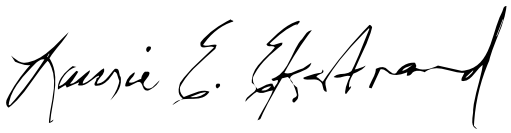
We received comments on a draft of this report from VA (reproduced in app. II). In commenting on the draft, VA stated that it agrees with our overall findings and generally concurs with the recommendations. VA stated that it concurs in principle that data on age, gender, and priority group status of veterans admitted to state veterans' nursing homes might be useful for strategic planning purposes, but contended that such data would have minimal value in strengthening the administration and oversight of state veterans' nursing homes. VA stated that it plans to collect demographic information on state veterans' nursing home patients on a more structured, routine basis. VA indicated that the collection of state veterans' nursing home demographic information on a more structured, routine basis requires the development of new software, which VA anticipates might be completed by the end of fiscal year 2007. In addition, VA agreed with our recommendations to clarify reimbursement policy on state veterans' nursing homes and stated that it plans to do so by issuing a national information letter to VA medical centers of jurisdiction by the end of fiscal year 2006.

VA stated that the data we recommended for strategic planning might be useful, but in its detailed comments said that VA has no authority to direct the location of state homes, restrict admissions to them, or limit per diem payments to particular categories of veterans. We believe, however, that VA can use these data to have substantial impact on strategic planning. First, VA can work with state veterans' nursing home programs on a cooperative basis to develop data and strategic planning initiatives. State veterans' nursing home officials in the four states we examined and in the National Association of State Veterans Homes indicated to us that they were willing to work with VA officials on strategic planning issues. Second, with comprehensive data on the three settings of its nursing home program—VA-operated nursing homes, privately owned nursing homes in the community from which VA purchases services, and state veterans' nursing homes—VA can provide Congress with strategic planning options and their potential impact on access and costs. As a result, decisionmakers can make more informed strategic planning decisions regarding VA-financed nursing care.

VA also commented that our report appears to reflect a misunderstanding about the nature of the state veterans' nursing home programs and VA's role in overseeing these programs. VA pointed out that states make decisions independently about their respective programs and as a result have admission criteria, financial arrangements, workload, and other aspects of their programs that differ. VA also said that it is prohibited by statute from intervening in the operations or management of state

veterans' nursing homes and characterized its role as limited to per diem reimbursements, construction grants, and program oversight through on-site inspections and financial audits. We substantially agree with VA on these points. Indeed, as we stated in the draft report, state veterans' nursing homes are managed and controlled by state entities, and states have the flexibility to establish different admission criteria and financial arrangements and choose the composition of their patient populations. Moreover, we do not believe that VA needs to directly intervene in state veterans' nursing home operations or management to respond to our recommendations.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staff have any questions about this report, please contact me at (202) 512-7101 or at ekstrandl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



Laurie E. Ekstrand
Director, Health Care

Appendix I: Scope and Methodology

To address the reporting objectives, we reviewed available national data on state veterans' nursing homes and obtained information from state veterans' nursing home programs in four states: Florida, Maine, Oklahoma, and Pennsylvania. We selected these states to reflect regional variations, differences in population density, whether or not state veterans' nursing homes in the state are certified for reimbursement by the Centers for Medicare & Medicaid Services (CMS), whether the state's nursing home program is stable or expanding in size, and whether the nursing homes tend to be of older or new construction. We discussed our selection with officials from the National Association of State Veterans Homes, who provided us with additional information on these programs.

To obtain information on admission criteria for state veterans' nursing homes, patients' age and gender, patients' lengths of stay, and sources of revenue for nursing home operations, we conducted site visits to nine state veterans' nursing homes in four states. We interviewed officials who manage the state veterans' nursing home programs in the four states. During the site visits, we also interviewed staff at the six Department of Veterans Affairs (VA) medical centers that perform oversight of these nine state veterans' nursing homes and obtained copies of VA's inspection protocol and interpretive guidelines for conducting oversight.

In addition to site visits, we used a data collection instrument to obtain data regarding age and gender of state veterans' nursing home patients, lengths of stay, and to identify sources and amounts of revenue used by the four states to finance their nursing home operations. We took steps to ensure that data we obtained from selected state veterans' nursing homes were sufficiently reliable for our purposes. For example, we verified the accuracy of state veterans' nursing home programs' data for internal consistency and correlated these data to information we obtained through interviews with officials and visits to the selected states. We also used data from the CMS Nursing Home Compare national database to identify states that have state veterans' nursing homes certified for Medicare or Medicaid reimbursement. For additional information on VA's national per diem and construction grant programs, we interviewed VA headquarters staff who administer these programs. To augment the information we collected, we reviewed state program Web sites and state veterans' nursing home program documents. We performed our review from December 2004 through March 2006 in accordance with generally accepted government auditing standards.

Appendix II: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 6, 2006

Commemorating 75 Years of Service

Ms. Laurie Ekstrand
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Ekstrand:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA LONG-TERM CARE: Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes*** (GAO-06-264). The Department agrees with GAO's overall findings and generally concurs with the recommendations. The enclosure provides additional discussion on the recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

R. James Nicholson

Enclosure

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT

VA LONG-TERM CARE: Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes
(GAO-06-264)

To help ensure that VA can conduct adequate strategic planning for nursing home care and strengthen its administration and oversight of state veterans' nursing homes, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following four actions:

- **Compile and report data on the age and gender of veterans admitted to state veterans' nursing homes.**
- **Compile available data on the priority group status of veterans in state veterans' nursing homes, and explore with these nursing homes options for estimating the number of enrolled veterans in each priority group.**
- **Clarify that state veterans' nursing homes may receive reimbursement from VA for services provided to veterans who have either wartime or peacetime military service.**
- **Clarify VA policy regarding whether state veterans' nursing homes may receive reimbursement from VA for nursing home services provided to new Priority Group 8 veterans admitted to state veterans' nursing homes.**

Concur in Principle – Many of the issues identified by GAO in this report are the same issues identified by GAO in its related 2004 report, (**GAO-04-1050, VA Long Term Care: *Oversight of Nursing Home Programs Impeded by Data Gaps***). The Department of Veterans Affairs' (VA) position remains essentially the same as expressed in our response to that report. VA concurs in principle that data on age, gender and priority group status of veterans admitted to state veterans' nursing homes might be useful for strategic planning purposes, but they would have minimal value in strengthening the administration and oversight of the state nursing homes. Veterans Health Administration (VHA) plans to collect demographic data on veterans in state veterans' homes (SVH) in a more structured, routine fashion as our data systems are refined to make such information available. New software development is required to incorporate the SVH requirements, and VHA anticipates the software updates might be completed by the end of FY 2007. As GAO is aware, VA does have access to date about our enrolled SVH veterans, and will continue to explore the feasibility

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT

VA LONG-TERM CARE: Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes
(GAO-06-264)
(Continued)

of aggregating such data, if required, prior to implementation of the updated data systems.

VA agrees with GAO's recommendations to clarify reimbursement regulations to SVHs with our field facilities. VHA's Geriatrics and Extended Care Strategic Healthcare Group plans to develop and issue a national Information Letter by the end of this fiscal year that will define reimbursement parameters.

GAO's report appears to reflect a misunderstanding about the nature of the SVH program and VA's role in overseeing that program. SVHs are owned, operated, managed and financed by individual states. As such, the SVHs significantly differ in their admissions criteria, financing arrangements, workload, etc., because individual states make independent decisions about their respective programs. VA's role is limited to providing financial assistance to the states in the form of construction and per diem grants, and providing oversight of the program through on-site inspections and financial audits. In fact, VA is expressly prohibited by statue from intervening in the operations or management of state veterans homes.

Further restricting VA's role is the fact that VA has no authority to direct the location of state homes, restrict admissions to them, or limit per diem payments to particular categories of veterans. A VA proposal in the FY 2006 budget proposal to impose limits on per diems was rejected by Congress, thereby maintaining a policy of continued payments for all eligible veterans. The state veterans' home per diem is a single, fixed, national rate that is not related to the level of care the individual veteran is receiving. To determine future fiscal obligations, VA estimates future increases in the per diem rate, based on VA's own projected medical care cost inflation, as well as the total occupancy of SVH beds, which includes projections of future increases in capacity based on current construction projects that are either underway or awaiting grant funding.

2

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Laurie E. Ekstrand, (202) 512-7101 or ekstrandl@gao.gov

Acknowledgments

In addition to the contact mentioned above, James C. Musselwhite, Assistant Director; Cheryl A. Brand; Fredrick K. Caison; Krister P. Friday; and Steven R. Gregory made key contributions to this report.

Related GAO Products

VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans. GAO-06-333T. Washington, D.C.: January 9, 2006.

VA Health Care: Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care. GAO-05-429. Washington, D.C.: August 5, 2005.

VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps. GAO-05-65. Washington, D.C.: November 10, 2004.

VA Long-Term Care: More Accurate Measure of Home-Based Primary Care Workload Is Needed. GAO-04-913. Washington, D.C.: September 8, 2004.

VA Long-Term Care: Changes in Service Delivery Raise Important Questions. GAO-04-425T. Washington, D.C.: January 28, 2004.

VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions. GAO-03-815T. Washington, D.C.: May 22, 2003.

VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care. GAO-03-487. Washington, D.C.: May 9, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. GAO-03-756T. Washington, D.C.: May 8, 2003.

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VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening. GAO-01-768. Washington, D.C.: July 27, 2001.

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