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Report To The Honorable Alan Cranston United States Senate

OF THE UNITED STATES

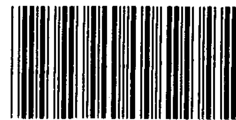
State Veterans' Homes: Opportunities To Reduce VA And State Costs And Improve Program Management

State homes provide hospital, nursing home,and domiciliary care to needy, disabled veterans. The Veterans Administration helps States to defray the costs of building and operating the homes through construction grants and per diem payments.

Both VA and the States could reduce their costs to operate the homes. VA could reduce its costs by independently verifying the levels of care needed by veterans admitted to State homes. Failure to do so resulted in overpayments to the three homes sampled at an annual rate of $450,000.

While States need additional revenues to offset increases in operating costs, there are alternatives to increased VA funding. State homes could obtain more money from veterans receiving VA pensions. Also, part of the cost of care provided to some veterans could be recovered from Medicare or private health insurance.

GAO offers a number of recommendations to reduce the cost of providing care in State homes and to improve program management.



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OCTOBER 22, 1981

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

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The Honorable Alan Cranston
United States Senate

Dear Senator Cranston:

This report is in response to your request, as Chairman of the Senate Committee on Veterans' Affairs, that we review selected aspects of the Veterans Administration's (VA's) State home program.

State homes are a cost-effective alternative to providing care in VA facilities. However, opportunities exist for both VA and the States to reduce their costs to operate the homes. VA could reduce its costs by independently verifying the levels of care needed by veterans admitted to State homes. States could reduce their costs by taking advantage of other sources of revenue, such as veterans' pensions and health insurance.

We asked VA and the nine State homes reviewed to submit comments on the matters discussed in this report. The State homes provided comments which have been incorporated in the report where appropriate. However, VA had not provided comments when the 30-day statutory comment period expired, and this report was finalized.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of issue. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE HONORABLE
ALAN CRANSTON
UNITED STATES SENATE

STATE VETERANS' HOMES: OPPORTUNITIES TO REDUCE VA AND STATE COSTS AND IMPROVE PROGRAM MANAGEMENT

D I G E S T

Opportunities exist for both the Veterans Administration (VA) and the States to reduce their costs of providing care to veterans in State homes. VA could reduce its costs by independently verifying the levels of care needed by veterans admitted to the homes. States could reduce their costs by taking advantage of other sources of revenues, such as veterans' pensions and health insurance.

State homes provide hospital, nursing home, and domiciliary care to needy, disabled veterans. During fiscal year 1980, the 43 State owned and operated homes provided care to about 11,400 veterans daily.

VA helps States defray the costs of operating and constructing State homes through per diem payments and construction grants. Per diem totaled about $35 million during fiscal year 1980, and since the first construction grants were awarded in 1966, over $96 million has been provided to States for constructing or renovating State homes. VA has helped the States construct over 6,000 nursing home beds. (See pp. 1 to 4.)

Senator Alan Cranston, as Chairman of the Senate Committee on Veterans' Affairs, requested that GAO review the State home program to find out if (1) VA was effectively administering the program, (2) the method used to help States pay for the care provided should be changed, and (3) the homes were capable of providing quality care. GAO included nine State homes in its review.

VA COSTS COULD BE REDUCED THROUGH BETTER ADMINISTRATION OF PER DIEM PROGRAM

Because VA was generally not properly certifying the levels of care needed by veterans admitted to State homes, hospital and nursing home per

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diem rates were paid unnecessarily for many veterans requiring lower levels of care. (See pp. 6 and 7.)

About 97 percent of the randomly sampled hospital care patients at the three homes GAO tested in this regard (in California, Connecticut, and Iowa) needed only nursing home care rather than the hospital care VA paid for. Similarly, about one-third of the patients for whom VA was paying nursing home rates at the Iowa home--the only home GAO tested in this regard--needed only domiciliary care. (See pp. 8 to 15.)

The improper certifications, which occurred because VA physicians were not independently verifying the patients' need for the levels of care requested by the homes, resulted in estimated overpayments to the three homes at the rate of about $450,000 annually. (See pp. 7 and 8.)

REIMBURSEMENT METHOD SHOULD NOT BE CHANGED

Legislation has been introduced in the Congress to change the method of reimbursing States for care provided to veterans in State homes. Each of the three methods proposed would have increased VA's costs by about $25 million in fiscal year 1980 and would likely result in VA paying a higher share of State home costs than the States in future years. (See pp. 34 to 38.)

Changes in the method of reimbursing States for the care provided to veterans in State homes are not needed. The homes have been able to maintain or expand the services provided to veterans under the current method.

While the States need additional revenues to offset increasing operating costs, alternatives to increased VA funding exist. State homes could obtain more revenues from veterans receiving VA pensions intended to help defray their costs of daily living.

For example, in May 1981, a single veteran with no dependents could receive up to $7,136 a year in VA pension benefits. If the veteran were provided nursing home care in a VA facility, VA would

reduce the veteran's pension to $720 a year. However, a veteran receiving nursing home care in the State home in Georgia would continue to receive the full pension because veterans receiving care in State homes are not subject to the VA pension reduction and the State does not charge veterans for their care. (See pp. 40 to 44.)

Also, part of the cost of care provided to some veterans could be recovered from Medicare or private health insurance. Only six of the nine homes reviewed were participating in the Medicare program, and only three were participating in the part of the program covering inpatient services. Those three homes received about $2 million from Medicare in fiscal year 1979.

The Massachusetts home recovered about 4 percent of its fiscal year 1979 operating costs from private health insurers. The success the Massachusetts home has had in recovering costs from private health insurance demonstrates the potential for other States to reduce their costs to operate State homes. (See pp. 44 and 45.)

CONSTRUCTION AND USE OF STATE, VA, AND COMMUNITY NURSING HOMES NOT EFFECTIVELY PLANNED

Because VA has not effectively planned and coordinated the construction or use of VA, State home, and contract community nursing homes, VA and State home facilities may be constructed in areas having too many community or State nursing home beds while not enough beds may be available in other areas to meet VA's anticipated needs.

VA predicts that the demand for VA-sponsored nursing home beds will increase by about 9,200 by 1985 and by over 30,000 by the year 2000. (See pp. 51 and 52.)

The availability of State and community nursing home beds has not been adequately considered in planning the construction of VA nursing homes.

In addition, a suggestion made in a 1972 GAO report that VA determine the need for State nursing homes before approving their construction has not been accepted.

VA planned to construct nursing homes in some medical districts that already had an excess of community and State nursing home beds. For example, both VA and the State of Minnesota plan to build nursing homes in Minneapolis although local health planning officials said there are too many nursing home beds in the city. (See pp. 52 to 58.)

VA has assumed the availability of State and community nursing homes to provide care to 60 percent of the VA-sponsored nursing home patients in 1985. However, some States have no State nursing homes and do not plan to construct any by 1985. Other areas have a shortage of community nursing home beds.

Because VA has not planned for the construction of VA facilities to compensate for the anticipated shortage of State and community nursing homes in some parts of the country, the agency may not be able to provide nursing home care to all eligible veterans living in these areas. (See pp. 58 to 60.)

STATE HOMES ARE CAPABLE OF PROVIDING PRIMARILY NURSING HOME AND DOMICILIARY CARE

State homes are capable of providing quality nursing home and domiciliary care to their patients, but have only limited acute hospital care capabilities. The eight State nursing homes providing nursing home care included in GAO's review were capable of providing a level of care at least comparable to that provided in most community nursing homes. Each of the eight homes providing domiciliary care reviewed was capable of providing medical services to its residents.

Although VA authorized three homes to operate hospitals ranging from 150 to 440 beds, none claimed to be operating an acute-care hospital with more than 66 beds. The three State homes lacked adequate staff and facilities to provide a full range of acute-care services to all of the beds recognized by VA as hospital beds. They were capable only of providing primarily a high level of skilled nursing home care to most beds.

Most hospital beds should be converted to nursing home beds, and only a few hospital beds should be maintained to meet the modest acute-care needs of home patients. Patients needing a higher level of

acute hospital care services should be referred to VA or community hospitals. (See pp. 20 to 22.)

VA INSPECTIONS MAY NOT IDENTIFY DEFICIENCIES

State homes are inspected by VA for compliance with its standards of care to identify and correct deficiencies in State home operations. However, inspectors were

--not evaluating surgical care provided by State home hospitals because standards for such care had not been developed and

--limiting the scope of their assessments, using various criteria to assess compliance with a single standard, or incorrectly assessing compliance because they had not been given adequate guidance.

VA modeled the State home standards after standards developed by the Department of Health and Human Services and the Joint Commission on Accreditation of Hospitals. However, VA's standards do not provide inspectors as much guidance on how to assess compliance. For example, the Department's standards tell inspectors how many and what kinds of records to review to assess compliance. The VA standards provide no such guidance. (See pp. 26 to 31.)

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

GAO is making a number of recommendations to the Administrator which will

--insure that payments to State homes are based on the levels of care needed by veterans admitted to the homes;

--improve VA's monitoring of the quality of care provided by State homes; and

--improve coordination between VA, State, and community officials in planning to meet the extended care needs of aging veterans. (See pp. 16, 24, 32, 46, and 61.)

AGENCY AND STATE HOME COMMENTS AND GAO'S EVALUATION

VA was given the opportunity to provide comments on a draft of this report. It had not done so when the 30-day statutory comment period expired.

The State homes generally disagreed with GAO's conclusion that the reimbursement method should not be changed and said that the Federal Government should pay a higher share of State home costs.

GAO believes that increased VA funding should be sought only after all other sources of revenues have been exhausted. All of the homes reviewed could have obtained additional revenues from veterans to decrease State or VA costs.

Several homes disagreed with GAO's conclusion that many veterans were placed at a higher level of care than required by their medical condition.

In GAO's judgment, the homes did not provide adequate justification for the per diem rates claimed. GAO's conclusions were based on review of the patients' medical records and discussions with VA and home officials about the level of care needs of the questioned patients. (See pp. 16, 25, 33, 46, and 61.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

In any deliberations on legislative proposals to change the per diem reimbursement method, the Congress should consider the extent to which the States are taking advantage of the alternative sources of revenues identified in this report.

The Congress should also consider amending 38 U.S.C. 3203 to extend the pension reduction criteria to cover care being furnished in State homes and authorize VA to transfer the money withheld to the States to help pay for the veterans' care. (See p. 50.)

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ABBREVIATIONS

GAO	General Accounting Office
HHS	Department of Health and Human Services
JCAH	Joint Commission on Accreditation of Hospitals
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

Senator Alan Cranston, as Chairman of the Senate Committee on Veterans' Affairs, requested that we review selected aspects of the Veterans Administration's (VA's) State home program, including the quality of care provided by the homes, the adequacy of Federal support to the program, and VA's administration of the program.

WHAT ARE STATE HOMES?

State homes are State-operated hospitals, nursing homes, and domiciliaries providing care primarily to disabled veterans incapable of earning a living. As of April 1981 there were 43 homes in 31 States and the District of Columbia. Of the 43 homes, 41 provide domiciliary care; 38, nursing home care; and 7, hospital care. In fiscal year 1980 State homes provided care to about 11,400 veterans daily.

State home hospitals provide diagnosis and treatment for inpatients with medical, surgical, or psychiatric conditions who generally require daily physician services with attendant diagnostic, therapeutic, and rehabilitative services. Nursing homes provide care to persons who are not acutely ill or in need of hospital care, but require skilled nursing care and related medical services. Domiciliaries provide shelter, food, and necessary medical care on an ambulatory self-care basis to veterans who are disabled by age or disease, but not in need of hospitalization or skilled nursing care services.

HOW DOES VA ASSIST THE STATES?

VA assists the States in defraying the cost of operating and constructing State home facilities through a program of per diem payments and construction grants.

VA pays States per diem rates 1/ of up to $6.35 for domiciliary, $12.10 for nursing home, and $13.25 for hospital care provided in State homes. By law (38 U.S.C. 641(b)), per diem paid on behalf of a veteran is limited to one-half the cost of the veteran's care in the home.

Also, under VA policy, per diem payments for a fiscal year may not exceed the difference between the total cost of providing care to eligible veterans and the amounts collected by the State

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1/VA paid States per diem rates of $5.50, $10.50, and $11.50 for domiciliary, nursing home, and hospital care, respectively, for the period January 1976 through September 1980.

from the veterans and other sources in their behalf. In other words, the per diem payments cannot result in the State collecting more than the total cost of providing care to veterans in a State home. Per diem payments to State homes during fiscal year 1980 totaled $35.2 million. (See app. II.)

VA is authorized 1/ to make grants to States to cover up to 65 percent of the cost of

--construction of new domiciliary or nursing home buildings;

--expansion, remodeling or alteration of existing domiciliary, nursing home, or hospital facilities;

--initial equipment for authorized facilities; and

--architect fees.

When the project is completed, no more than 25 percent of the bed occupancy shall be used to care for other than eligible veterans.

The construction grant program was established in 1964, but funds were not appropriated until fiscal year 1966. About $117.2 million has been appropriated for State home construction between fiscal years 1966 and 1981, and as of September 30, 1980, grant funds totaling about $96.8 million had been committed or obligated for 148 projects which will provide 6,135 State nursing home beds. (See app. III.)

ARE STATE HOMES A COST-EFFECTIVE ALTERNATIVE TO VA AND COMMUNITY NURSING HOMES?

Because VA pays only part of the cost of care provided to veterans in State homes, such care generally costs VA less than does care provided in VA or contract community 2/ nursing homes. In addition, it costs VA less to support 65 percent of the cost of constructing State nursing home beds than to construct its own facilities.

In fiscal year 1980, nursing home care provided in State homes cost an average of $41 a day. VA paid the States $10.50 to help

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1/38 U.S.C. 5031-5037.

2/VA contracts with private nursing homes to provide care to veterans. Veterans requiring nursing home care for service-connected conditions may be placed indefinitely at VA expense, while nonservice-connected veterans may be placed in community facilities at VA expense for up to 6 months.

defray the cost of care provided to veterans. In contrast, nursing home care provided in VA facilities cost VA an average of about $75 per day, and care provided in contract community nursing homes cost an average of about $37 per day.

VA's assistant chief medical director for extended care said that, although the statistics suggest that care in VA facilities is much more costly than care in community or State home facilities, there are significant differences in the care provided. According to him, the average cost of care is higher in VA nursing homes because they provide care to veterans with more complex and extensive medical, rehabilitative, or psychiatric needs than do most State or community nursing homes. However, he agreed that the veteran in a State home could not have been provided care in a VA or community nursing home at a lower cost to the Government.

Expansion of VA's nursing home capabilities by constructing additional State home beds costs the Government less than constructing VA nursing homes. In April 1980 five States had applications pending for construction of nursing homes. VA's 65-percent share of the estimated cost of constructing the 620 nursing home beds was about $12 million, or about $19,000 per bed. In contrast, VA planned the construction of seven nursing homes in 1981. The estimated cost of constructing the seven homes' 720 beds was over $77,000 per bed.

WHO IS ELIGIBLE FOR CARE IN A STATE HOME?

Each State establishes the eligibility requirements for admission to its home(s). VA has no direct control over admissions, and the homes may admit both veterans and nonveterans. However, VA pays States per diem only for care provided to veterans who meet the eligibility requirements for admission to a VA health care facility. Generally, a veteran is eligible for care if he or she has (1) a service-connected disability or (2) a nonservice-connected disability and is unable to defray the expenses of necessary hospital, nursing home, or domiciliary care (38 U.S.C. 610(a) and (b)).

To be eligible for participation in the State home program, a home must be used primarily to provide care to veterans. Most States have limited admissions to their homes to veterans or veterans and their spouses.

HOW DOES VA ADMINISTER THE PROGRAM?

VA administers the per diem and construction grant programs and conducts annual inspections of State home facilities. However, it has no direct management control over State home operations. VA's State home manual sets forth the agency's policies and procedures for carrying out its responsibilities.

The assistant chief medical director for extended care, a staff position in VA central office's Department of Medicine and Surgery, is responsible for administering the State home program. He is supported by a State home coordinator, who manages and carries out central office program functions.

Primary responsibility for administering the per diem program has been delegated to 36 "facilities of jurisdiction," usually VA medical centers. These facilities establish the number of authorized beds for each level of care, certify eligibility of veterans claimed for per diem payments, maintain health records on each veteran and a register of days of care provided by level of care, and make initial and annual inspections of State homes to establish their qualifications and to insure compliance with VA standards of care.

The construction grant program is administered entirely at the central office, and only the Administrator can commit grant funds.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to determine whether

--State homes were capable of providing quality care and whether they had adequate staffing;

--patients were placed at the proper level of care;

--VA State home standards of care were comparable to standards developed by the Joint Commission on Accreditation of Hospitals (JCAH) and the Department of Health and Human Services (HHS);

--VA's inspection program had been implemented adequately;

--the method for assisting States to defray the costs of care provided to veterans should be changed;

--VA effectively planned and coordinated the construction and/or use of VA, State, and community nursing homes to meet the estimated needs for nursing home beds; and

--VA should have done more to encourage participation in the State home program.

To accomplish these objectives, we visited nine State homes and the eight VA medical centers responsible for administering the program at those homes. At each home, we interviewed officials and reviewed records concerning the types of programs and services provided, level of care placement criteria and decisions, the costs of operations, and the need for additional VA funding.

In addition, we reviewed the medical records of random samples of veterans (1) at each home to determine whether patient needs were being identified and the care provided properly documented and (2) at three homes to determine whether veterans were placed at the proper levels of care.

At the VA medical centers, we interviewed the physicians, nurses, social workers, and others who conducted the State home inspections and the physicians responsible for certifying the levels of care needed by veterans admitted to State homes. We also reviewed records and regulations concerning the medical center's role in monitoring the care provided, insuring the accuracy of VA per diem payments, and assessing compliance with standards. (See app. I for more details on our work steps and limitations.)

CHAPTER 2

VERIFYING LEVELS OF CARE VETERANS

NEED COULD REDUCE COSTS

VA could have reduced per diem payments to States by properly certifying the levels of care for veterans admitted to State homes. Because VA physicians generally were not independently verifying the levels of care needed, VA paid per diem for care higher than the levels indicated by veterans' medical conditions. Random samples of hospital patients at the California and Connecticut homes and hospital, nursing home, and domiciliary patients at the Iowa home showed that

--97 percent of the veterans for whom VA was paying hospital per diem rates required only nursing home care and

--about one-third of the patients at the Iowa home for whom VA was paying nursing home per diem rates required only domiciliary care.

The sample results indicate overpayments to the three States at the rate of about $450,000 a year.

In addition, the admission and/or placement policies of the California, Georgia, and South Carolina nursing homes created a potential for overpayments to the homes.

VA PHYSICIANS NOT ADEQUATELY CERTIFYING LEVEL OF CARE REQUIRED

VA medical centers generally did not comply with a VA regulation (38 CFR 17.166d) requiring that the levels of care needed by veterans admitted to State homes be independently determined. Although we reported to the Administrator of Veterans Affairs in 1972 that physicians at some medical centers were not determining the need for nursing home care before approving per diem payments, 1/ the problem was still widespread in 1980. Only one of the eight centers we visited independently determined the levels of care needed by veterans admitted to State homes before approving per diem payments. VA physicians were not always aware that they could (1) require homes to provide additional data to justify the requested per diem or (2) approve payment of per diem at a rate other than that requested.

1/September 14, 1972, B-167656.

VA's State home manual requires State homes to apply for per diem for each veteran admitted. VA administrative personnel determine the veteran's eligibility for care. The veteran's medical need for hospital, nursing home, or domiciliary care is to be independently determined by a VA physician based on information submitted by the home and the definitions of hospital, nursing home, and domiciliary care contained in the manual.

The forms used record the veteran's medical history and physical examination data and must contain sufficient medical information to justify the level of care requested. The VA physician's signature on the form certifies the level of care needed and establishes the per diem rate at which the home will be paid.

The St. Louis medical center had a physician independently determine the levels of care required by veterans admitted to the Missouri home. In contrast,

--the Columbia and Seattle medical centers' physicians did not review or sign the forms;

--the Northampton and San Francisco centers' physicians certified that veterans needed care at the State home, but did not determine the specific levels of care needed; and

--the Dublin, Newington, and Des Moines centers' physicians certified levels of care, but approved whatever placements were made by the homes' physicians.

At the Seattle and Northampton centers, certifying physicians said they could not independently verify the level of care needed without examining the patient. However, the certifying physicians at five other centers said that they could determine the required level of care by reviewing the forms submitted by the homes. The State home manual states that the certifying physician can require the home to provide additional information if the information submitted is not sufficient to justify the level of care requested.

At the San Francisco center, the certifying physician stated that he had to approve the requested level of care because he could not tell the home to move the veteran to a different level of care. Although VA physicians cannot direct a State home to move a veteran to a lower level of care, VA physicians can authorize payment at a lower per diem rate than that requested.

IMPROPER CERTIFICATION OF LEVELS OF CARE COSTLY TO VA

Because VA's per diem payment to a State depends on the level of care at which a veteran is certified, approving levels of care higher than that justified is costly. Veterans certified for care

at levels higher than justified by their medical conditions resulted in excess per diem payments at three homes at the rate of about $450,000 annually.

To measure the extent to which VA could reduce program costs through proper level of care determinations, we reviewed the level of care certifications for random samples of veterans at three State homes. Our medical advisor visited the three homes, reviewed each patient's medical record, visited selected patients, and discussed the patients' needs with home and VA medical center physicians. He reviewed the records of 186 hospital, 45 nursing home, and 19 domiciliary patients. (See p. 9.) Using the State home manual definitions of levels of care, he evaluated each patient's needs. He found that (1) most patients certified at the hospital per diem rate at the three homes needed only nursing home care, (2) about one-third of the patients certified at the nursing home per diem rate at the Iowa home needed only domiciliary care, and (3) domiciliary patients at the Iowa home were properly certified.

We estimate that 295 (92.5 percent) of the 319 veterans certified at the hospital per diem rate at the California home, 302 (100 percent) of the veterans certified at the hospital rate at the Connecticut home, and 230 (42.5 percent) of the 541 hospital, nursing home, and domiciliary patients at the Iowa home were certified at a higher level of care than they needed. The 827 residents certified at the wrong level of care resulted in overpayments of $1,232 per day or at the rate of $450,000 annually. (California home, $108,000; Connecticut home, $110,000; and Iowa home, $232,000). 1/

The following sections provide details on our evaluation of hospital and nursing home placements and the views of home and VA medical center officials on our findings.

STATE HOME HOSPITALS HAVE FEW ACUTE-CARE PATIENTS

Of the sampled patients VA certified as hospital patients at the California, Connecticut, and Iowa homes, 97 percent could have been properly cared for at a nursing home. All of the VA-authorized hospital beds at the Iowa home and 85 percent of those

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1/At the 95-percent confidence level, the misclassification ratio could vary by ±5.7 percent at California, -3 percent at Connecticut, and ±11 percent at Iowa. The estimated amount of excess per diem payments at the 95-percent confidence level for each home is $295 ±$18 at California, $302 - $9 at Connecticut, and $635 ± $164 at Iowa. Because our sample was selected from each home's population on a single day, we could not compute confidence limits to make an annual projection of overpayments.

at the California home were State-licensed only as nursing home beds. And, although the beds at the Connecticut home were State-licensed as acute or chronic hospital beds, a review of the hospital's patients by a professional standards review organization 1/ showed that most patients needed only nursing home care.

VA's State home manual states that hospital care

> "* * * means providing diagnosis and treatment for inpatients with medical, surgical or psychiatric conditions who generally require the services of a physician on a daily basis with attendant diagnostic, therapeutic and rehabilitative services. A hospital facility providing such care will be operated by or under the direct supervision of a physician."

According to the assistant chief medical director for extended care, the definition is that of an acute-care hospital and clearly states that patients in State home hospitals should need almost daily physician services.

Of the sampled patients certified at the hospital per diem rate, 97 percent were in need of nursing home rather than hospital care because they did not require and generally were not receiving daily physician visits. As the following table shows, VA medical center or home officials agreed that each of the 180 hospital patients we considered incorrectly certified were not in need of and were not receiving acute hospital care. Of the 180, no more than 18 were challenged, and in each case either VA or home officials agreed with our determination.

Home	Patients sampled	Number of patients not receiving acute hospital care		
		GAO	VA	Home
California	81	75 (93%)	a/65	75
Connecticut	86	86 (100%)	86	73
Iowa	19	19 (100%)	b/17	19
	186	180 (97%)	168	167

a/The San Francisco VA medical center did not review five of the California home's cases.

b/The Des Moines VA medical center did not review two of the cases because the veterans had been transferred to the nursing home between our review and VA's review.

1/Such organizations have responsibility for the comprehensive, ongoing review of hospital services under the Medicare, Medicaid, and Maternal and Child Health programs.

Officials at the California home and the San Francisco VA medical center said that the patients which they agreed were not in need of acute hospital care were nursing home patients. Both the California home's administrator and chief medical officer said that 374 of the 440 beds that VA recognizes as hospital beds were licensed by the State only for skilled or intermediate nursing home care. VA's assistant chief medical director for extended care agreed that VA should have paid nursing home per diem for patients in the 374 beds licensed as nursing home beds.

The Iowa and Connecticut homes' commandants told us that the patients who did not need acute hospital care were "chronic" or "intermediate" level hospital patients. According to VA's assistant chief medical director for extended care, intermediate level hospital care is between acute hospital and nursing home care. He said the primary difference between intermediate hospital care and skilled nursing home care is that intermediate hospital patients need almost daily physician visits. He said that, although the State home manual defines hospital care as acute care, VA has long recognized the ability of State home hospitals to provide intermediate hospital care.

Even if chronic or intermediate hospital care were included within the State home definition of hospital care, the patients reviewed at the Iowa and Connecticut homes were still incorrectly certified because they did not require the almost daily medical intervention that differentiates intermediate level hospital patients from nursing home patients.

Further, all of the 150 VA-authorized hospital beds at the Iowa home were licensed by the State only for nursing home care. The Des Moines VA medical center physician who inspected the Iowa home in 1980 said that all 134 patients in the home's hospital at the time of his inspection were in need of nursing home rather than hospital care.

Although the Connecticut home's hospital is licensed by the State for acute and chronic hospital care, officials from the Newington VA medical center agreed that the patients we reviewed needed only nursing home care. The Hartford County Professional Standards Review Organization reviewed the records of the 259 patients in the hospital on January 1, 1981, and concluded that only 12 needed acute or intermediate hospital care.

SOME NURSING HOME PATIENTS COULD FUNCTION IN A DOMICILIARY

The criteria the Iowa home used to place veterans in its nursing home were inconsistent with VA placement criteria. Veterans who would be placed in a domiciliary under VA's level of care definitions were placed in the Iowa nursing home. The medical records

of a random sample of Iowa nursing home patients showed that VA should have paid the domiciliary per diem rate for about one-third of them.

Although we did not review random samples of veterans in nursing homes at the South Carolina, Georgia, and California homes, indications were that some patients at each home should have been certified at the domiciliary per diem rate.

According to VA regulations (38 C.F.R. 17.47), domiciliary patients must have the ability to

--perform without assistance daily ablutions, such as brushing teeth, bathing, combing hair, and body eliminations;

--dress with a minimum of assistance;

--proceed to and return from the dining hall without aid;

--feed themselves;

--secure medical attention on an ambulatory basis or by use of a personally propelled wheelchair;

--have voluntary control over body eliminations or control them by use of an appropriate prosthesis;

--share in some measure, however slight, in the maintenance and operation of the facility; and

--make rational and competent decisions as to their desire to remain at or leave the facility.

<u>Many Iowa patients could function in a domiciliary</u>

Under the Iowa home's admission criteria, veterans meeting the VA definition of a domiciliary patient may be placed in the nursing home. The home's admission criteria state that a veteran will be placed in the nursing home if he or she

--has control of his or her body eliminations,

--has the ability to transfer from the bed and toilet or independently care for a urinal,

--has the ability to get to the desk for medications or to take medications by him or herself,

--does not require continuous oxygen,

--is ambulatory (with or without appliances) without assistance,

--is generally independent in his or her activities of daily living,

--is generally able to make his or her own bed on a daily basis, and

--is able to clean or arrange his or her own bedside area.

To confirm that the Iowa home's admission criteria and the Des Moines VA medical center's certification practices resulted in VA's paying nursing home per diem rates for veterans in need of domiciliary care, we reviewed, with the assistance of our medical advisor, the latest physical examination and medical records of 45 randomly selected nursing home patients and discussed the patients' needs with home officials.

The medical records indicated that 18 patients required only domiciliary care because they (1) did not require the skilled care of a nurse and (2) generally had no medical problems which would require services available only in a nursing home. After discussions with home officials, we reduced this number to 15. The medical conditions of the 15 patients were well controlled with medications, and the patients were independent in their activities of daily living, ambulatory with mechanical aids, competent to seek out care as needed, and generally capable of travel without the aid of an attendant.

At our request the Des Moines VA medical center's certifying physician reviewed the latest physical examinations for 12 of the Iowa home's patients, including 4 of the nursing home patients that we believed were incorrectly certified. The VA physician was not told what levels of care the patients were receiving or what levels of care we believed they required. Using the VA State home manual's level of care definitions, the VA physician determined that the four nursing home patients should be certified as domiciliary patients.

Officials at the Iowa home generally disagreed. For only 1 of the 15 patients did they agree that the level of care was too high, and that patient was later transferred to the domiciliary. The officials said that the other 14 belonged in the nursing home because they

--could not function in the domiciliary because of facility limitations in the Iowa domiciliary or

--had behavioral problems requiring the structure and supervision available only in the nursing home.

Patients placed in nursing home because of facility limitations

Home officials generally agreed that 6 of the 14 patients could have functioned in a domiciliary but said they were placed in the nursing home because of facility limitations at the Iowa home's domiciliary. We agree. However, facility limitations at a State home do not justify payment of per diem at the nursing home level if a veteran could--except for the facility limitations--function in a domiciliary. Accordingly, the six veterans should have been certified by the Des Moines medical center at the domiciliary rather than nursing home per diem rate.

Patients need structure and supervision of nursing home

The home's staff said that the other eight patients had behavioral problems requiring the structure and supervision available only at the nursing home. Structure and supervision, as described by the home's staff, is the availability of trained staff such as nurses, social workers, and activities personnel to encourage and supervise residents in making everyday decisions they find too burdensome to make by themselves. The home staff further stated that their level of care placement system considers patients' psychosocial needs as well as nursing and medical needs. In the opinion of the home's staff, however, the definition of nursing home care contained in the VA State home manual does not go far enough in addressing patients' psychosocial needs as a determinant of level of care.

We do not believe the home officials identified any services required by the eight patients that could not have been provided in the domiciliary. Under VA standards, a domiciliary must have staff with a documented mental health background to help employees be aware of and manage patients' psychosocial problems. The Iowa home's domiciliary had higher social work and drug and alcohol abuse counseling staff-to-patient ratios than did the nursing home. In addition, both nursing and activities personnel were assigned to the domiciliary.

The patients' medical records indicated that all medical or nursing services they required were available in the domiciliary. The medical records showed that the eight patients were competent, well oriented, alert, and ambulatory. They performed daily living activities without assistance from a nurse and generally administered their own medications. The medical records showed that the patients diagnosed as having psychiatric disorders were well controlled on medications. In our opinion, they could have functioned in the domiciliary. Some patients also had dietary and alcoholism problems, but we believe that these conditions could also have been controlled in the domiciliary.

In a May 14, 1979, letter, VA's assistant chief medical director for extended care informed all VA medical centers that State home patients should be considered nursing home patients only if they require a service available only in the nursing home. Because the home did not identify the need for any service that could not have been provided in the domiciliary, we believe that VA should have certified the eight patients at the domiciliary per diem rate.

Patients at three other homes may be incorrectly certified

The admission or placement policies of three other nursing homes indicated that VA may be paying nursing home per diem rates for veterans who need only domiciliary care. At the homes in California, Georgia, and South Carolina, there was a high potential for such overpayments. At the other four homes visited--in Massachusetts, Missouri, and Washington (Orting and Retsil)--there was low potential for such overpayments.

South Carolina War Veterans Home

Although the Columbia VA medical center referred many veterans in need of domiciliary care to the South Carolina home, it certified all patients admitted to the home at the nursing home per diem rate. No VA physician reviewed or signed the forms approving the per diem payment.

Officials at the Columbia VA medical center told us that the South Carolina home accepted only minimal- and self-care patients. They believed many of the patients the medical center referred to the State home could have been placed in a domiciliary if one had been available. They said that the State home did not have a domiciliary and that the nearest VA domiciliary was 175 miles from Columbia.

Georgia State War Veterans Home

The Georgia home used placement criteria that were inconsistent with VA level of care definitions. VA must independently verify the levels of care veterans admitted to the home need to insure that per diem payments are correct. However, the Dublin VA medical center approved per diem at the level of care the home requested without independently determining the level of care needed.

The Georgia home's description of its lowest category of nursing home patient fits a patient meeting VA's definition of a domiciliary patient. The home characterizes the lowest of its four categories of nursing home patients as those who

--are essentially self-care,

--have little or no deviation from normal behavior,

--have little or no restriction of activity, and

--care for themselves and their personal belongings.

As of August 31, 1980, about 10 percent of the approximately 250 nursing home patients were in this category.

Veterans Home of California

The California home staff's descriptions of the assistance needed by its nursing home and domiciliary patients were inconsistent with VA criteria describing the assistance such patients should need. To insure that per diem payments are correct, VA must independently determine the levels of care needed by veterans admitted to the home. However, the San Francisco VA medical center approved payment of per diem without determining the appropriateness of the rate the home requested.

According to the home physicians and nurses we talked to, patients placed in the domiciliary must be self-sufficient, able to handle daily living activities without assistance, and able to administer their own medications. They said that patients who needed any assistance were placed in the nursing home. In contrast, under VA criteria, veterans who require some minimal assistance in dressing themselves or taking medications can be housed in the domiciliary.

According to one of the home's physicians, about 5 to 10 percent of the nursing home patients could function in the home's domiciliaries.

CONCLUSIONS

Having physicians certify the levels of care needed by veterans admitted to State homes is a key control to insure that per diem payments are correct. VA paid hospital or nursing home per diem rates for many veterans requiring lower levels of care because of a widespread breakdown in the system of controls. Although we advised the Administrator of Veterans Affairs of the problem in 1972, it persists. VA could reduce per diem payments to States by independently verifying the levels of care needed by veterans admitted to State homes.

Because there is no clear distinction between intermediate hospital care and skilled nursing home care, VA should approve payment at the hospital per diem rate only if the patient needs acute hospital care.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the chief medical director:

--Reemphasize to VA physicians the importance of independently verifying the level of care needs of veterans admitted to State homes.

--Inform VA physicians of their options to request additional data from the State home to justify the requested level of care and to authorize payment of per diem at a rate other than that requested.

--Direct VA physicians to approve payment of the hospital per diem rate only if the patient needs acute hospital care.

--Direct VA medical centers that are clinics of jurisdiction for the State home program to review the appropriateness of the per diem rates paid for veterans already in State homes and adjust per diem payments as necessary. The appropriateness of per diem rates should be determined by a VA physician using the level of care definitions in the State home manual.

AGENCY AND STATE HOME COMMENTS AND OUR EVALUATION

VA was given the opportunity to provide comments on a draft of this report. It had not done so when the 30-day statutory comment period expired, and this report was finalized.

Five State homes submitted written comments on a draft of this report. The other four State homes provided oral comments. These comments and our evaluation are incorporated in this and succeeding chapters.

Iowa Veterans Home

The Iowa home's commandant did not agree that many of the home's hospital and nursing home patients could function at a lower level of care. (See app. IV.) He said that the professional staff at the home and VA medical center are duly qualified to recommend and approve an appropriate level of care. He said that our conclusion that one-third of the patients for whom VA was paying nursing home per diem rates needed only domiciliary care was based on the opinion of one individual who made a brief review of charts and a 1-day visit to the facility. According to the commandant, it is one thing to read a record and briefly observe patients and another to have a working knowledge of patients' functioning in

regard to the level of care placement, keeping in mind the patients' total needs for care. He said that, after all of the discussion pertinent to particular patients in the Iowa home, it seems that we gave minimal importance to the total care concept for the veterans, involving the psychosocial and physical level of functioning.

While our preliminary assessment of the level of care needs of the Iowa nursing home patients was based on our medical advisor's review of medical records and patient visits, an equally important part of our assessment was our discussion with the Iowa home's staff and review of additional data supplied by the home to justify the level of care placements. Only after giving consideration to the data supplied by the Iowa home's physicians, nurses, and social workers did we conclude that the patients could have functioned in a domiciliary.

The Iowa home's commandant said that he has never considered the hospital care offered at the home to be acute care but that he definitely feels that the home does provide an intermediate level of hospital care. He said that the home's physicians do make daily rounds and that the home does have and does provide necessary attendant services for such care. He said that nowhere in the State home manual's definition of hospital care is the word "acute" found.

As stated on page 10, the Iowa home's "hospital" is licensed by the State to provide nursing home not hospital care. In addition, VA's 1980 inspection of the home found that the "hospital's" patients were in need of nursing home rather than hospital care.

Connecticut Veterans' Home and Hospital

The Connecticut home's commandant advised us that he found the draft report to be objective, informative, and essentially accurate in its findings and recommendations, but disagreed with the report's finding with regard to certifying levels of care. (See app. V.) He said that the home's hospital is licensed by the State and accredited by JCAH as a 350-bed facility with 50 acute and 300 chronic beds. According to the commandant, VA's level of care definitions do not embrace the concept of long-term chronic care and effectively relegate patients in that category to nursing home care. He said that our study was constrained to the VA definitions, and as a result, patients were either acute hospital or nursing home patients. He said that the same limitation applied to the professional standards review organization study referred to on page 10.

The commandant said that the statement that VA overpaid for care is inaccurate and offensive. He said that patients treated at the Connecticut home's hospital received the level of care appropriate to their medical condition, and the cost was less than

would have been incurred elsewhere, even in a VA-operated nursing home. He said that, while some of the patients may not have met the VA definition for hospital level, it is not certain that they could have been adequately managed in a nursing home setting without the ancillary services of a hospital.

As stated on page 10, even if chronic hospital care were included within the State home definition of hospital care, the patients reviewed at the Connecticut home were incorrectly certified because they did not require the almost daily medical intervention that differentiates chronic hospital patients and nursing home patients. Further, the professional standards review organization said that only 12 of the 259 Connecticut hospital patients it reviewed needed either acute or chronic hospital care, and the VA medical center said that all of the patients we reviewed needed only nursing home care.

Georgia War Veterans Home

The Georgia home's director agreed that there is "a grey area" between the home's category four skilled nursing home patients and a domiciliary patient, but he does not believe the home's admission policies create a potential for overpayments. (See app. VI.) He said that no veteran is assigned to the nursing home until (1) an application has been aproved by a screening committee consisting of physicians, registered nurses, social workers, and psychologists, (2) the application has been approved by VA, and (3) the applicant completes a medical examination by the admitting physician. He said that applicants that do not meet medical entry criteria at any step of the processing are denied admission to skilled nursing.

The Georgia home's director said that the home's placement criteria do not appear to be contradictory or at variance with those of VA and that there was no intent to be inconsistent. He said that they do not place a veteran in skilled nursing until VA agrees with their placement recommendations and the admitting physician has conducted a physical examination to verify the medical reports. According to the director, the home's physicians, assisted by other professional staff, determine levels of care required by an applicant based on the diagnosis suported by medical history and physical findings.

The home's director said that, to be eligible for care in the nursing home, a veteran must not be acutely ill and not in need of hospital or domiciliary care, but require skilled nursing care and related medical services prescribed by and under the general direction of persons duly licensed to provide such care, must be approved for skilled care by VA, and shall require one or more of the following levels of care:

--Performance of any direct services that the physician judges can be provided safely only by home personnel.

--Continuous care by nursing personnel at the level of a licensed practical nurse or higher.

--Observation by a registered professional nurse or a licensed practical nurse at least once daily, and assessment of the total needs of the patient by such personnel.

--Administration and/or control of medications by licensed nursing care personnel, such as administration of routine medicines and injections.

--A treatment plan including planning and administration of multiple services prescribed by a physician, such as care of a totally bedridden patient.

--Continuing medical and nursing care of sufficient degree to necessitate the maintenance of a continuing clinical record.

Our concern at the Georgia home related only to the category four patients the home's director admitted are in a "grey area" between nursing home and domiciliary care. Such patients constitute only about 10 percent of the home's total nursing home patients. We agree that the admission procedures cited in the director's letter should help insure the proper placement of patients at the home. However, one key part of those admission procedures--certification by a VA physician--was not being properly done. The VA physicians were certifying whatever level of care the home requested.

South Carolina War Veterans' Home

The South Carolina home's administrator did not feel that the home was admitting patients to the nursing home who could have functioned in a domiciliary. He said patients admitted to the home are looked at both physically and psychologically and that he does not believe there have been many inappropriate admissions. He said that the level of care needs of the home's patients have been discussed with the home's doctors and that they agreed that most of the patients at the home could not function at any lower level of care.

We believe that statements of VA medical center officials that they were referring veterans to the South Carolina nursing home who needed only domiciliary care indicate the potential for overpayments to the home. Although we did not review a random sample of nursing home patients at the home to determine the extent to which overpayments were actually occurring, some of the home's nursing personnel told us that they believe many of the home's patients could function in a domiciliary.

CHAPTER 3

STATE HOMES CAPABLE OF PROVIDING QUALITY NURSING HOME AND DOMICILIARY CARE, BUT SOME IMPROVEMENTS NEEDED

Although improvements were needed in the operation of each State home visited to insure that patients receive timely physical and dental examinations and physician visits and that the care provided was properly documented, each home providing nursing home and/or domiciliary care was capable of providing quality care. The State home hospitals lacked adequate staff and facilities to enable them to provide a full range of acute-care services. However, most hospital patients we reviewed required only the skilled nursing home care the home was capable of providing. (See ch. 2.)

STATE HOMES CAPABLE OF PROVIDING PRIMARILY NURSING HOME AND DOMICILIARY CARE

Our medical advisor reviewed profiles on nine homes and visited the California, Iowa, and Connecticut homes to determine whether they had adequate staff, facilities, and services to provide quality care to the homes' patients. The eight nursing homes were capable of providing quality care at least comparable to that provided in most community nursing homes, and the eight domiciliaries were capable of meeting residents' medical needs. The three hospitals our medical advisor visited, 1/ however, were capable of providing primarily a high level of skilled nursing home care.

The attitude of the homes' personnel, the maintenance of the facilities, the services provided, and the involvement of patients in recreational and social activities were excellent. Each home presented a pleasant atmosphere with clean, neat, and odor-free buildings and grounds and comfortable accommodations for residents. Although some homes were old, most buildings had undergone substantial renovation in recent years. Residents were well groomed, and some were observed actively participating in social and recreational activities. Services provided by the homes had been adjusted to meet changing patient needs.

The State home profiles reviewed by our medical advisor included

--the levels of care provided;

1/Our medical advisor did not visit the Massachusetts home and did not evaluate its capability to provide acute-care hospital services.

--the age and renovation dates of each building, what they were used for, and their bed capacity;

--demographic data about the residents, such as their average age, the number of males and females, and the common medical diagnoses;

--the average number of residents provided each type of care, the source of admission, and the average length of stay;

--arrangements with other medical facilities to provide services not available at the home;

--our staff's observations on the cleanliness of the home, the appearance of the facilities and grounds, the dress and grooming of residents, and the involvement of residents in recreational and other activities;

--descriptions of the services and special facilities provided, the methods used to provide the services, and the number of home staff available to provide services; and

--the number of nurses scheduled to work each day.

In his review our medical advisor emphasized the homes' nurse staffing patterns, medical care referral arrangements (including the availability of physicians), the availability of ancillary services (such as physical therapy, occupational therapy, speech therapy, and social services), and the availability of special facilities to provide such services as rehabilitation, radiology, and laboratory.

Although the Iowa, Connecticut, and California homes were authorized by VA to operate hospitals ranging in size from 150 to 440 beds, the homes were capable of providing acute hospital services to only a few patients. None of the homes claimed to be providing acute care to more than 66 beds. The availability of two physicians on site at the Iowa home, for example, was a plus for the home, but two physicians could not provide hospital-type care to a large number of patients. The Iowa home recognized that it was not capable of providing acute hospital care and referred patients needing such care to VA or community hospitals.

Similarly, the California and Connecticut homes were not equipped and staffed to provide acute hospital care to large numbers of patients. However, the hospitals were capable of providing a modest level of acute care to a few patients.

According to the California home's administrator, VA has traditionally authorized payment of hospital per diem rates for patients in all 440 beds in the building housing the home's hospital, but the home operates only a 66-bed acute-care hospital. He said that

the other 374 beds are licensed by the State as nursing home beds. According to the administrator, the home has adequate staffing and facilities to provide acute care to patients in the 66 beds.

SOME HOMES NOT ADEQUATELY IDENTIFYING NEEDS AND DOCUMENTING CARE

Many veterans at the nine homes did not receive physician visits, physical examinations, and dental examinations as often as they should according to VA standards. In addition, physicians orders, progress notes, medication charts, nursing plans, rehabilitation plans, and social histories and plans of care were not always prepared, reviewed, or properly documented.

A random sample of 30 1/ medical records was reviewed at each home to determine whether patient needs were being identified and documented in each level of care and whether the care provided was being properly documented based on VA's State home standards. We assessed the records 2/ against 12 VA standards, such as whether

--hospital patients received daily and nursing home patients monthly physician visits,

--nursing home and domiciliary patients received annual physicals,

--domiciliary patients received annual dental examinations,

--social histories were prepared, and

--nursing plans of care were prepared.

We considered the home deficient if the criteria were not met in 15 percent or more of the cases reviewed and the criteria were not met in at least two cases. Deficiencies existed at one or more homes in all but one area reviewed. For example:

1/At the Massachusetts home 33 records were reviewed.

2/The number of medical records reviewed for compliance with an individual criterion was generally less than 30 because some criteria applied only to (1) one or two levels of care, (2) residents admitted after July 1979, (3) residents in the home for more than 1 year, or (4) residents who required a particular service such as rehabilitation.

--Two of eight homes (in Missouri and Iowa) were not providing monthly physician visits to nursing home patients. 1/

--Three of eight homes (in Massachusetts, Iowa, and Washington (Orting)) had not provided annual physicals within 16 months to some nursing home patients. 2/ At the time of our site visit, the Iowa home was catching up on annual physicals.

--Four of eight domiciliaries (in California, Connecticut, Missouri, and Washington (Retsil)) were not preparing nursing plans of care for the residents. 3/

1/Based on review of the medical records of 17 nursing home patients at the Iowa home and 20 nursing home patients at the Missouri home. None of the nursing home patients at the two homes were receiving monthly physician visits.

2/Based on review of the medical records of 18 nursing home patients at the Massachusetts home, 17 at the Iowa home, and 10 at the Washington (Orting) home who had been in the home at least 1 year at the time of our review. Physicals had not been provided within the last 16 months to 4 (22 percent) of the nursing home patients sampled at the Massachusetts home, 8 (47 percent) at the Iowa home, and 9 (90 percent) at the Washington (Orting) home. The time since the last physical ranged from 16 months to over 4 years.

3/Based on review of the medical records of 11 domiciliary residents at the California home, 10 at the Missouri home, 20 at the Washington (Retsil) home, and 20 at the Connecticut home. Nursing plans of care had been prepared for only 1 of the 61 domiciliary residents reviewed at the four homes. The California home's administrator and chief medical officer said that the VA standard is inappropriate and that developing nursing plans of care for domiciliary residents at the California home would be an exercise in futility. They said that the California home's domiciliary is used strictly as a home, whereas VA's domiciliaries are used for rehabilitation. They said that the annual physicals provided to home residents are adequate to set patient goals and that the ambulatory care program is adequate to meet followup needs.

--Five of nine homes (in California, Massachusetts, Washington (Orting), Washington (Retsil), and Connecticut) had not prepared social histories on all patients. 1/

--Two of eight domiciliaries (in California and Missouri) had not provided an annual dental examination to all domiciliary residents. 2/

CONCLUSIONS

State homes are an important part of VA's extended care program because they can provide quality nursing home and domiciliary care at costs to VA that are generally lower than the costs of care in VA or contract community facilities. However, States should be encouraged to convert most hospital beds to nursing home beds and maintain only a few hospital beds to meet the modest acute-care needs of home patients. Other acute-care patients should be referred to VA or community hospitals.

State homes should strengthen procedures for identifying and documenting patient needs and documenting the care provided.

RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the chief medical director, encourage State homes to convert hospital beds, other than those needed to meet the short-term acute-care needs of home patients, to nursing home beds.

1/Based on review of the medical records of 30 patients at the California, Washington (Orting), Washington (Retsil), and Connecticut homes and 33 patients at the Massachusetts home. Social histories had not been prepared for 7 (23 percent) of the domiciliary, nursing home, and hospital patients at the California home, for 18 (55 percent) of the patients at the Massachusetts home, for 6 of the 14 domiciliary residents at the Washington (Orting) home, or for any of the 30 patients reviewed at the Washington (Retsil) and Connecticut homes. The Massachusetts home was completing social histories at the time of our visit.

2/Based on review of the medical records of eight domiciliary residents at the California home and six domiciliary records at the Missouri home. None of the Missouri domiciliary residents had received an annual dental examination and three (38 percent) of the California residents had not received an annual examination.

STATE HOME COMMENTS

Iowa Veterans Home

The Iowa home's commandant said that he feels the home provides care for patients beyond the scope of community nursing homes. He said that the home's admissions reflect the increased need for the many health services the home provides. We agree that the home was capable of providing a level of skilled nursing home care above that found in most community nursing homes.

Soldiers' Home in Holyoke

The superintendent of the Massachusetts home pointed out that the home is reviewed and inspected by JCAH, the Department of Public Health, and VA on a continuous basis. He said that they have always received accreditation from JCAH.

CHAPTER 4

VA MONITORING OF CARE PROVIDED BY STATE HOMES NEEDS TO BE IMPROVED

Although annual inspections of State homes to assess compliance with standards of care are VA's primary means of identifying and correcting deficiencies in the care provided by State homes, the inspection process had not been effectively implemented. VA inspectors were not evaluating the surgical care provided by State home hospitals because the agency had not established standards of care for surgery and related services. Where standards existed, inspectors limited the scope of their assessments, used different criteria to assess compliance with a standard, or incorrectly scored standards as met because they had not been given adequate guidance on how to assess compliance. Deficiencies identified during the inspections were sometimes incorrectly reported on final inspection reports.

IMPROVEMENTS NEEDED IN VA'S STANDARDS OF CARE

VA modeled State home hospital and nursing home standards of care after JCAH and HHS standards, and domiciliary standards after criteria used to evaluate VA's own domiciliaries. However, VA State home standards did not cover surgical care and related medical services, although State home hospitals perform surgery, and did not provide as much guidance on how to assess compliance with the standards as did the JCAH and HHS standards. VA training sessions provided little additional guidance on how to assess compliance with the standards.

As a result, VA inspectors sometimes (1) scored standards as met solely because a service was provided, even though the service was not considered adequate to meet patient needs, (2) used different criteria to assess compliance, and (3) did not assess the quality of surgical and related medical services at homes providing those services.

VA developed the State home standards in response to the Veterans Omnibus Health Care Act of 1976, which stated that:

> "No payment or grant may be made to any home * * * unless such home is determined by the Administrator to meet such standards as the Administrator shall prescribe * * *."

The standards were first used during the 1979 State home inspections.

VA's State home coordinator developed the standards of care with assistance from VA's nursing home and domiciliary coordinators and modeled the standards primarily after existing HHS, JCAH, and VA standards. The standards were sent to the National Association of State Veterans' Homes and to each State home for review and comment, but neither the Association nor any of the homes provided formal comments. The Association did provide draft comments, and VA made at least two changes in the final standards which addressed the Association's major objections. 1/

According to the California home's administrator, the home was inspected in 1978 using the State home standards and the home first saw the standards a couple of days before the inspection.

Need to develop surgical standards

VA's hospital standards did not address surgical care and related services even though three of the four State home hospitals we reviewed perform surgery. Both JCAH and HHS hospital standards cover surgical care and related services, such as anesthesia and blood tranfusions, and require, for example, that

--operating room rules, regulations, and policies be posted;

--traffic to and from the operating rooms be controlled;

--minimum equipment requirements be met;

--a registered nurse be in charge of the operating rooms;

--a complete patient history and physical examination be completed before surgery;

--surgical assistants meet certain qualifications; and

--a postsurgery report be prepared on techniques used in performing the surgery and the surgical findings.

VA's assistant chief medical director for extended care advised us in a December 30, 1980, letter that:

"Standards for State home hospital care did not include standards for surgery and other related services because the Veterans Administration did not want to encourage surgery in State home

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1/VA deleted standards requiring that (1) 25 percent of the nursing staff at a nursing home be registered nurses and (2) homes maintain a minimum core staffing ratio of 1.0 employees per patient.

facilities. The Veterans Administration believes that surgery should be performed at well equipped medical centers."

However, surgery was performed at the California, Connecticut, and Massachusetts homes. Information obtained at the California and Connecticut homes indicated that both major and minor surgery was being performed. The Iowa hospital performed no surgery.

The 1979 VA inspection reports for the California, Connecticut, and Massachusetts homes contained no evaluation of the surgical care the homes provided. The lack of State home standards for surgical care may be the cause of VA inspectors omitting surgical care from their inspections of State home hospitals.

Need for more detailed standards

Because VA standards of care do not give inspectors adequate guidance on how to assess compliance, VA inspectors limited the scope of their assessments, used different criteria to assess compliance with standards, or scored standards as met when they did not know how to assess compliance.

VA standards direct inspectors to evidence similar to the types of evidence considered by JCAH and HHS inspectors. The standards indicate that inspectors should

--examine written policies and procedures;

--review licenses and certificates;

--review medical records;

--check compliance with applicable Federal, State, and local laws and regulations;

--make observations of equipment, services, facilities, and staff; and

--interview staff.

However, JCAH and HHS standards give inspectors more guidance on how to obtain accurate information and reach reliable conclusions about compliance with standards. 1/ For example, JCAH standards refer inspectors to assessment checklists identifying questions to be addressed in assessing compliance with a standard. Similarly, HHS standards refer inspectors to interpretive guidelines and survey procedures providing details on such matters as how many and what kind of records to review and how to evaluate staff qualifications.

VA central office officials agreed that detailed written criteria such as those provided by JCAH and HHS have not been provided by VA, but said that VA inspectors were given guidance on how to assess compliance with the State home standards through workshops held before the 1979 inspections. Inspectors from the eight medical centers in our review had mixed opinions on the adequacy of the training provided in the workshops, but most said that the training did not provide enough guidance on the inspection process. Inspectors received no written materials other than the VA inspection forms.

To determine the extent to which the limited guidance provided to VA inspectors affected their ability to assess compliance with the standards, we asked inspectors from the eight medical centers in our review to describe how they assessed compliance with 80 VA standards during the 1979 State home inspections (including 27 hospital, 33 nursing home, and 20 domiciliary standards). Inspectors' responses indicated that they used inconsistent criteria, did not fully assess, or did not know how to assess compliance with 44 of the 80 standards. The following examples show that many problems were caused by the lack of specific guidance on how to assess compliance with the standards.

Example 1

A nursing home standard requires that there be "adequate space in the bedrooms and other treatment areas for unimpeded movement of patients and staff." VA provided no other written guidance for assessing compliance with the standard.

1/Even with additional guidance inspectors may not always assess standards correctly. In 1979 and 1981, we reported that HHS or JCAH standards were inconsistently assessed. "The Medicare Hospital Certification System Needs Reform" (HRD-79-37, May 14, 1979) and "Analysis of Proposed New Standards for Nursing Homes Participating in Medicare and Medicaid" (HRD-81-50, Feb. 20, 1981).

The inspector from the Northampton medical center told us that the Massachusetts home did not meet the standard because rooms in the facility contained as many as 16 beds. The inspector assessed compliance with the standard using the criterion established for use when planning the construction of VA nursing homes. The criterion states that nursing homes will contain no more than four beds per room. In contrast, the inspector from the San Francisco medical center decided that the California home met the requirements of the standard, even though rooms had as many as 34 beds.

The corresponding HHS standard specifies that nursing home rooms may have no more than four beds and that single-bed rooms must measure at least 100 square feet while multi-bed rooms must provide at least 80 square feet per bed. If the VA standard had contained the criteria in the HHS standard, both the Massachusetts and California homes would not have been in compliance.

Example 2

A nursing home standard requires that

"A qualified professional social worker is on the facility staff, or there is a written agreement with a qualified social worker or recognized social agency for consultation on a regularly scheduled basis."

The standard did not require the inspector to determine whether the home had enough social workers. As a result, some inspectors marked the standard as met without determining whether the home had enough social workers to meet the needs of all patients.

The Seattle medical center inspector told us that he was concerned that social work staffing at the Washington homes at Orting and Retsil was inadequate. However, he scored the standard as met because he thought the standard addressed only the availability of the service, not the adequacy of the staffing. Similarly, the San Francisco medical center inspector told us she scored the standard as met at the California home because the social worker was licensed, although she believed that one qualified social worker was not enough to meet the needs of the home's patients.

JCAH and HHS standards require not only that social services exist, but also that nursing homes have enough social work staff to meet the needs of all patients. This requires the inspector to make a judgment as to whether the staff is sufficient to meet the patients' needs. Had VA inspectors been provided the additional guidance in the JCAH and HHS standards, they likely would have reported the staff shortages they noted in social services at the California and two Washington homes.

VA central office officials told us that the inspectors' problems in assessing compliance with State home standards may have been partly caused by the fact that the standards of care were first used by the inspection teams in fiscal year 1979. However, they agreed that more specific criteria are needed to help inspectors assess compliance with State home standards and said that they plan to include the standards in the Systematic Criteria Evaluative Measurements study currently being conducted. According to the assistant chief medical director for extended care, VA faces a difficult task in adhering to the requirement that the agency not be involved in managing State homes yet still provide detailed quality of care standards. He said that a fine line divides the two.

INSPECTION REPORTS CONTAINED OMISSIONS AND ERRORS

VA inspection reports contained numerous omissions and clerical errors. In several cases standards not met were left blank or incorrectly scored as met on the final inspection report. Although VA's central office reviewed the final inspection reports, it generally did not ask the medical centers about standards that were not assessed.

To determine the extent of omissions and reporting errors in inspection reports, we reviewed the final VA inspection reports and, when available, the supporting documentation for the nine homes we visited. The medical centers issued the reports with 46 out of a possible 1,087 standards (about 4 percent) not scored at all or not scored consistently with the supporting documentation. The final inspection reports should have shown at least 10 of the 46 standards as not met.

VA's central office reviewed the final inspection reports and told the medical centers to follow up on the unmet standards, but did not ask the medical centers about standards that were not scored on five of the six inspection reports that had unscored standards. Only for the Washington home at Orting did central office officials comment on two unscored standards. In that case, however, three unscored standards were not mentioned.

To determine the extent to which other medical centers were not scoring standards on final inspection reports, we reviewed the 1979 reports for all but two homes. 1/ About 5 percent of the standards were not scored.

1/Inspection reports from the Rhode Island home, the Pennsylvania home at Hollidaysburg, and the domiciliary report for the New Jersey home at Menlo Park were not available at the time of our review. The report for the nursing home at Menlo Park was reviewed.

VA medical centers incorrectly scored some standards on final reports. By comparing the inspectors' originals to the final inspection reports for six of the nine homes, 1/ we identified six standards that were scored as met on the final inspection report although the inspectors had scored them as not met. Medical center officials told us they believed the standards were incorrectly scored because of clerical errors. Had the standards been scored correctly, the homes would have been asked to provide a plan of action to correct the deficiencies and the VA medical centers would have been expected to follow up to insure that the problems were corrected.

For example, the nursing home standard requiring that food be prepared and stored in a sanitary manner was scored by the San Francisco inspector as not met at the California home, but was scored as met on the final report. The Medical Administrative Service inspection team leader said that the standard was inadvertently scored as met and none of the inspector's comments on the home's deficiencies were included because of a clerical error. He said that the mistake caused many of the deficiencies to go uncorrected for an additional year.

CONCLUSIONS

Deficiencies in State homes were not always identified and corrected because VA inspectors did not know how to assess compliance with VA standards of care. The guidance given VA inspectors should be upgraded to match that given HHS and JCAH inspectors. In addition, standards for surgical care should be developed and the accuracy and completeness of inspection reports improved.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the chief medical director:

--Develop standards on surgical care and related services as part of the State home hospital standards.

--Revise State home standards to provide specificity and guidance such as that provided in JCAH and HHS standards.

--Follow up on inspection reports to insure that compliance with all standards is assessed.

1/Individual inspectors' reports were not available at the Washington home at Orting, the Connecticut home, or the Iowa home.

STATE HOME COMMENTS AND OUR EVALUATION

Iowa Veterans Home

The Iowa home's commandant said that he believes that standards of care are important in the delivery of services, but at the same time, increases in staffing cost money. He said that these increased costs should be shared more equitably by the Federal Government.

None of the homes we visited--including Iowa--was able to identify any increased costs due to the State home standards. We doubt that the State home standards significantly increase State home costs since they were patterned after existing JCAH and HHS standards.

CHAPTER 5

CHANGE IN REIMBURSEMENT

METHOD NOT NEEDED

Legislation introduced in both Houses of Congress would change the method of reimbursing States for care provided to veterans in State homes. The legislation would substantially increase Federal spending and likely result in VA paying a larger share of State home costs than the States in future years. The current level of VA funding has not limited the ability of the State homes we visited to provide quality care.

While the State homes need additional revenues to offset increasing operating costs, alternatives to increased Federal funding exist. State homes could obtain more revenues from veterans receiving VA pension and aid and attendance moneys intended to help defray their costs of daily living. Also, part of the cost of care provided to some veterans could be recovered from Medicare and/or private health insurance.

ALTERNATIVE REIMBURSEMENT METHODS COULD RESULT IN VA PAYING MORE THAN STATES

Since 1974 the National Association of State Veterans Homes, citing the unequal sharing of costs between VA and the States, has tried to develop an alternative to VA's per diem payment method. The proposed alternatives, however, would have increased VA's costs by about $25 million in fiscal year 1980 and would not result in the more equal sharing of State home costs sought by the Association. Further, we found no indication that, in establishing the per diem program, the Congress intended that VA share equally in State home operating costs.

The Association proposed three alternative reimbursement methods, each of which has been introduced in the House or the Senate. Each of the proposed methods of establishing per diem rates would consider each home's actual cost of providing care.

Under H.R. 6263, introduced in the 96th Congress, VA would have computed the national average cost of care for each level of care provided by State homes. The home would receive the lesser of half the national average or half its actual costs.

Under H.R. 2832 and S. 1034, introduced in the 97th Congress, State home per diem rates would be based on per diem costs in VA facilities. For each level of care, a home would be paid the lesser of (1) half the home's costs for each level of care or (2) 30 percent of VA's cost of providing such care.

Under H.R. 518, introduced in the 97th Congress, VA would compute the national average cost of care provided by State homes for the combined levels of care. The homes would receive the lesser of (1) half the national average cost of care or (2) half their actual cost of care.

Alternative methods would increase VA costs

As shown by the following table, each of the three methods would have increased VA per diem payments to State homes by about $24 million to $26 million in fiscal year 1980.

Comparison of the
Amount of VA Per Diem Payments and Percentage
of Total Home Costs
That Would Have Been Paid in 1980
Under Alternative Methods

Methods	Amount of VA per diem payment	VA participation rate
	(millions)	(percent)
Present system	$35.2	23
H.R. 6263	59.1	39
H.R. 2832 (S.1034)	60.8	40
H.R. 518	59.0	39

The table on the following page shows how the three methods would have increased fiscal year 1980 VA per diem payments to selected homes.

Comparison of Per Diem Rates That Would Have Been in Effect Under Alternative Reimbursement Methods to Actual 1980 Per Diem Rates

H.R. 6263 - 50 percent of cost by level of care

Home and level of care	Calculation of per diem rates that would have been in effect in FY 1980: One-half home's 1979 cost	One-half 1979 national average	Per diem that would have been paid	Actual 1980 per diem
California home:				
Domiciliary	$ 8.96	$10.66	$ 8.96	$ 5.50
Nursing home	11.93	17.96	11.93	10.50
Hospital	23.30	29.32	23.30	11.50
Iowa home:				
Domiciliary	17.27	10.66	10.66	5.50
Nursing home	19.50	17.96	17.96	10.50
Hospital	39.10	29.32	29.32	11.50

H.R. 2832 (S.1034) - 30 percent of VA cost by level of care

Home and level of care	Calculation of per diem rates that would have been in effect in FY 1980: One-half home's 1980 cost	30 percent of 1979 VA cost	Per diem that would have been paid	Actual 1980 per diem
Soldiers Home in Chelsea, Mass.:				
Domiciliary	$ 8.56	$ 7.69	$ 7.69	$ 5.50
Nursing home	14.20	19.70	14.20	10.50
Hospital	74.08	41.83	41.83	11.50
Washington home in Orting:				
Domiciliary	16.49	7.69	7.69	5.50
Nursing home	24.76	19.70	19.70	10.50

H.R. 518 - 50 percent of cost for all levels of care

Home	Calculation of per diem rates that would have been in effect in FY 1980: One-half home's 1979 cost for all levels	One-half 1979 national average for all levels	Per diem that would have been paid
California	$13.64	$15.56	$13.64
Iowa	23.95	15.56	15.56
Missouri	9.42	15.56	9.42

VA likely to pay more than States

In April 1979 testimony before the Senate Committee on Veterans' Affairs, Association officials said that the primary benefit of the alternative reimbursement methods would be a more equal sharing of costs between States and VA. The officials said that the States would still probably bear more than 50 percent of the cost, but that the ratio of VA to State costs would be much closer to 50-50. Analysis shows, however, that, had any of the proposed payment methods been implemented in fiscal year 1979, six of the nine homes reviewed would have received less than 50 percent of their funds from the State.

Although VA reimbursed States for only about 27 percent of the cost of providing care to veterans in 1979, the other 73 percent was not completely funded by the States. Reimbursements from Medicare, private health insurance, and veterans' contributions reduced the amount of State funds required to operate the homes. Georgia was the only State in our review that funded the entire difference. The following table shows the percentage of 1979 State home operating costs paid by VA, the States, and other sources.

	Percent of FY 1979 State home costs paid		
State home	VA	State	Other
California	23	57	20
Connecticut	22	65	13
Georgia	15	85	0
Iowa	20	49	31
Massachusetts	19	71	10
Missouri	46	9	45
South Carolina	31	55	14
Washington (Orting)	21	50	29
Washington (Retsil)	22	61	17

VA's per diem payments would have exceeded State funding at five homes if the alternative reimbursement method had been implemented in fiscal year 1979. The following table shows the percentage of veteran cost of care that would have been funded by VA, State, and other sources at the Iowa and Washington (Orting) homes.

Home and source of income	Percent of veteran cost of care funded by each source of income		
	H.R. 6263	H.R. 2832 (S.1034)	H.R. 518
Washington home (Orting):			
VA per diem payments	36	35	40
Other sources of income	29	29	29
State funding	35	36	31
Iowa home:			
VA per diem payments	38	43	31
Other sources of income	31	31	31
State funding	31	26	38

Furthermore, while VA would be paying a fixed ratio of State home costs, the States would not. As shown on pages 40 to 45, States could further reduce their costs by effectively using veterans' contributions and by seeing that other sources of revenue, such as Medicare and private health insurance, are used as much as possible.

NO INTENT TO SHARE EQUALLY IN STATE HOME OPERATING COST

In establishing the per diem reimbursement, the Congress intended to help States defray the cost of caring for disabled veterans. However, the legislative history shows that the Congress did not intend to establish an equal sharing of State home costs between VA and the States by having most States receive the maximum 50-percent Federal contribution allowed by law.

In its report on the 1976 increase in per diem rates, the Senate Committee on Veterans' Affairs stated that the increase would

> "* * * keep the Federal proportional share of operating costs at levels consistent with the average Federal proportional share during the past five years - approximately 30 percent."

In enacting the latest increase in per diem rates, the Congress indicated that it did not want to be tied into a fixed ratio reimbursement. The Senate Committee, in its report on the 1980 per diem increase, recommended that State homes be given only a 15-percent increase, although the Consumer Price Index had increased over 23.4 percent during the 3-year period of fiscal years 1977-79.

Based on the above, we conclude that the VA reimbursement program is one of a flat rate reimbursement and not fixed proportional cost reimbursement.

NO IMPACT DUE TO THE LEVEL OF VA PER DIEM RATES PAID

The current level of VA funding has not hampered the ability of the State homes we visited to provide quality care. All the homes have been able to increase or maintain the authorized staffing levels needed to provide the services discussed in chapter 3, even though VA's per diem rates have not kept pace with inflation. Operating costs for the nine homes increased by 31 percent between fiscal years 1977 and 1979, but the State homes have been able to obtain the necessary additional funds from State appropriations, veterans' contributions, or other sources.

States have approved increasing home budgets

State homes have not experienced significant problems in obtaining State approval of their operating budgets, but expect future approvals to be more difficult. Except for the South Carolina home, each of the homes received an annual operating budget from the State legislature, and VA per diem payments were deposited in the State's general treasury. The homes reviewed had received approval by State legislatures for increases in their annual operating budgets of from 26 to 103 percent between fiscal years 1977 and 1980. However, officials from five homes predicted that future approvals would be more difficult.

Commandants at the Georgia, South Carolina, Iowa, and both Washington homes expressed concern that future requests would not win easy approval because

- --State legislatures are making a concerted effort to hold down costs and

- --States are facing a period of reduced revenues.

We did not discuss problems in obtaining budget approvals with officials from the Massachusetts and Connecticut homes, but the homes' operating budgets had increased 40 and 37 percent, respectively, over the 4-year period.

Quality of care not related to VA per diem rates

The level of per diem paid has not adversely affected the quality of care provided. Commandants at the nine homes were unable to identify any specific problems directly related to the level of VA per diem. The five commandants who commented said that no direct relationship existed between the per diem rates and the quality of care provided.

VETERANS COULD CONTRIBUTE MORE TOWARD COST OF CARE

Veterans provided care in State homes receive VA pension benefits that they would not receive if they were provided care in a VA facility. 1/ Although such benefits are intended to be used by veterans to pay daily living and other needs, none of the homes we visited effectively used the pension and aid and attendance funds to defray the cost of care. In addition, veterans' other income could have been used to help defray the cost of their care and thus reduce State funding.

Wartime veterans with limited income, who are totally and permanently disabled from reasons not traceable to service, are usually eligible for pension benefits under the Improved Disability Pension program (Public Law 95-588). 2/ Benefits are based on the veteran's income, marital status, and number of dependents, and on whether the veteran needs the regular assistance of another person (referred to as aid and attendance). Pensions are reduced by the amount of veteran income on a dollar-for-dollar basis. Pensions are increased annually at the same rate as Social Security payments (14.3 and 11.2 percent in 1980 and 1981, respectively). The maximum pensions payable as of June 1, 1980, were:

Status of veteran	Maximum annual pension
Veteran without dependent (spouse or child)	$4,460
Veteran with one dependent (spouse or child)	5,844
Veteran in need of regular aid and attendance without dependents	7,136
Veteran in need of regular aid and attendance with one dependent	8,519

Over 50 percent of the veterans in State homes in 1979 received VA pensions. When we visited the Iowa home in 1980, 80 percent of the veterans were receiving pensions, 67 percent of whom were receiving Improved Disability Pensions as veterans with no

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1/Includes care provided by contract community nursing homes.

2/Some veterans receive benefits under pension programs enacted before the Improved Disability Pension. These pensions are commonly referred to as (1) Spanish-American War Service Pension, (2) Old Law Pension, and (3) Section 306 Pension (Public Law 86-211).

dependents. At the Missouri home the records of 25 randomly selected veterans showed that all 1/ were receiving pensions.

When a veteran is provided care by a VA hospital, nursing home, or domiciliary or by a contract community nursing home, the veteran's pension is reduced because the intended purposes of both the pension and aid and attendance benefits are met by VA. The pension and aid and attendance of a veteran without a spouse or dependent is reduced to an amount not more than $60 a month after 2 full calendar months of domiciliary care or 3 calendar months of hospital or nursing home care. In 1980, about 64 percent of the veterans receiving Improved Disability Pensions had no spouse or dependents. In addition, aid and attendance is reduced for a veteran with a spouse or dependent.

However, the pension reductions generally 2/ do not apply to veterans provided care in a State home because VA per diem covers only a part of the homes' costs. As a result, a veteran receiving care in a State home rather than in a VA or contract community facility had pension moneys of up to $6,416 3/ per year (based on rates effective June 1, 1980) that could have been used to help pay for the care received.

Application of VA pension reduction criteria could reduce need for State funds

If State homes collected amounts equal to VA's, they could significantly reduce the State's cost of care. However, none of the nine homes we visited had attempted to charge veterans anywhere near the amount called for by VA's pension reduction criteria. And, one home--Georgia--allowed veterans to keep all of

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1/The St. Louis VA Regional Office was unable to provide the necessary computer printouts to enable us to make a determination on the other five cases.

2/Pensions for veterans in State homes are reduced by VA only if the veteran is single with no dependents, rated incompetent by VA because of mental illness, and has an estate which equals or exceeds $1,500.

3/A veteran with no dependents receiving maximum annual pension benefits of $7,136 continues to receive these benefits while obtaining nursing home care in a State home. By contrast, the veteran would receive pension benefits of only $720 per year if care were provided in a VA or contract community nursing home. Since State homes are providing the needed care, the $6,416 in pension moneys could be collected and used to reduce State funding.

the pension and aid and attendance moneys received from VA to defray their cost of care.

In 1980, State homes could have collected up to about $18 a day from hospital and nursing home patients with no dependents who were receiving maximum pension and aid and attendance benefits, and up to $10 a day from domiciliary patients using the VA pension reduction criteria. In fiscal year 1980, these revenues, when combined with VA per diem payments, would have covered 40 percent of the national average State home cost for hospital care, 69 percent of the cost for nursing home care, and 66 percent of the cost for domiciliary care. The following table provides additional details.

Percent of Average State Home Costs Recoverable Through Per Diem and Pension Income for Veteran With No Dependent Who Received Maximum Pension Benefits

	Hospital	Nursing home	Domiciliary
Average daily State home cost during fiscal year 1980	$71.97	$40.81	$23.74
Daily per diem rates paid by VA during fiscal year 1980	$11.50	$10.50	$5.50
Daily pension amounts available if VA pension reduction criteria followed (note a)	17.58	17.58	10.24
Total moneys available for providing care	$29.08	$28.08	$15.74
Percent of State home cost	40	69	66

a/Daily amounts for hospital and nursing home patients based on $7,136 annual pension (effective June 1, 1980) for veteran in need of regular aid and attendance without dependents less $720 amount VA allows veteran to retain divided by 365 days. Daily amount for domiciliary was calculated on same basis as hospital and nursing home except an annual pension of $4,460 for veteran without dependents and no aid and attendance was used in calculating daily amount.

To demonstrate the potential revenue available to the States, we applied the charging criteria of each of the eight homes providing nursing home care and the VA pension reduction criteria to the $595 maximum monthly pension and aid and attendance benefits of

a veteran with no dependents and no other source of income. 1/ As shown by the following table, the homes would have received an additional $77 to $535 by applying VA's criteria.

Criteria applied	Income collected by home	Income retained by the veteran	Additional income available to home
VA	$535	$ 60	$ 0
California	370	225	165
Georgia	0	595	535
Iowa	458	137	77
Massachusetts	223	372	312
Missouri	320	275	215
South Carolina	234	361	301
Washington (Orting and Retsil)	435	160	100

Veterans have other sources of income

In fiscal year 1979, the nine homes we visited collected about $7.2 million from veterans for their care, ranging from $0 at Georgia to $2.4 million at Iowa. However, most veterans appear to have additional income that could be applied to the cost of care. VA officials said that most veterans in State homes would generally have a combination of pension benefits and other income that at least equals the maximum pension amount. Other sources of income include social security and VA compensation payments.

A legislative analyst for the State of California 2/ demonstrated the potential for reducing State funding through a charging system that maximizes veteran contributions. The analyst found that 16 of the 20 (excluding California) State homes having income-based fee schedules generated more revenue per capita from veteran contributions than did the California home. As a result, the home adopted a new charging policy effective October 1, 1980.

The following schedule shows the veterans' contributions that would have been generated by applying the fee schedules of the 16 States as well as the contributions that were generated by the old California fee schedule.

1/Based on pension rates in effect June 1, 1980, to May 31, 1981.

2/Chapter 1277, Statutes of 1978 (SB 1626), required the legislative analyst to report to the California legislature on the equity of the fee schedule used by the Veterans' Home of California.

State schedule	Revenue generated
California	$1,719,851
Oklahoma	2,132,388
New Jersey	2,571,185
Missouri	2,933,640
Washington	3,348,000
Wyoming	3,616,200
Michigan	3,656,280
Minnesota	3,705,577
Pennsylvania	3,713,280
Iowa	4,141,428
New Hampshire	4,174,320
Vermont	4,285,308
Illinois	4,462,848
Kansas	4,742,184
Nebraska	4,816,248
Indiana	5,161,500
Wisconsin	5,209,308

At least nine other State homes generated less revenue than the California home and thus have greater potential to increase revenue.

The Massachusetts home has been authorized to charge veterans for their care since 1970, but the home did not develop a charging plan until after we began our review. According to estimates developed by home officials, they could collect $1.15 million annually if they collect the full amount authorized by the State legislature. In fiscal year 1979, contributions under the plan would have reduced the State's share of the homes' operating cost from 71 to 53 percent.

RECOVERIES FROM HEALTH INSURANCE COULD FURTHER REDUCE STATE FUNDING

State funding could be further reduced by collecting from Medicare and private health insurers for services provided to veterans having such insurance. Many veterans obtaining care at State homes are eligible for Medicare 1/ benefits and/or have

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1/Medicare is an HHS program authorized by title XVIII of the Social Security Act to provide for the medical care of the elderly. The program is divided into two parts. Part A covers inpatient hospital services and posthospital care in extended-care facilties and in the patients' home. Part B covers physician services and other related health and medical benefits, including outpatient hospital services, certain home health care, and diagnostic tests performed by independent laboratories.

private health insurance. However, only six of the nine homes we visited were participating in Medicare, and only three were certified for participation in Medicare Part A. The Georgia, Missouri, and South Carolina homes were not participating in either Medicare Part A or Part B. In addition, State homes may be able to recover the costs of some services from private health insurers.

State homes having hospitals or nursing homes that meet HHS standards are eligible for certification as providers of Medicare Part A services. However, only the California, Connecticut, and Massachusetts homes had obtained such certification. During 1979, the California home recovered about $1.1 million from Medicare, the Connecticut home about $639,000, and the Massachusetts home about $239,000. We believe other homes may have been eligible for Part A certification for some of their beds. For example, the Georgia home could probably have obtained certification because it was licensed by the State as a skilled nursing home. The home's director said that State law does not allow the home to participate in either Medicare Part A or Part B.

All homes may seek certification and/or approval as providers of Medicare Part B services, such as laboratory, X-ray, and physician services. Although we did not develop estimates of the potential Part B recoveries at each home, we found that the Iowa home recovered about $55,000 during 1979 for physician services.

Most private health insurance policies contain an exclusionary clause stating that the policy does not cover the cost of care provided in Federal or State institutions. In a June 10, 1981, report 1/ we recommended that the Congress amend the Federal Medical Care Recovery Act (Public Law 87-693) to authorize Federal agencies to recover health care costs from private health insurers.

One State included in our review--Massachusetts--had taken action to recover such costs from private health insurers. In 1960, the Commonwealth of Massachusetts passed a law (chapter 339, Act of 1960) requiring that insurance companies underwriting in that State pay for services provided to their customers by State homes. In fiscal year 1979 the Massachusetts home collected about $200,000 from private health insurers, or 4 percent of the home's operating costs.

The success of the Massachusetts home in recovering costs from private health insurance demonstrates the potential for other States to reduce their costs to operate State homes.

1/"Cost Cutting Measures Possible If Public Health Service Hospital System Is Continued" (HRD-81-62).

CONCLUSIONS

Changes in the method of reimbursing States for the care provided to veterans in State homes are not needed. The homes have been able to maintain or expand the services provided to veterans under the current method.

While States need additional revenues to help offset increasing State home operating costs, they should take full advantage of other sources of revenues before seeking increased VA funding. At the minimum, States should collect from veterans receiving pensions an amount equal to the reduction that would occur if the veteran obtained care in a VA facility. In addition, States should collect funds from veterans having other sources of income according to the veterans' ability to pay. To the extent possible, States should also collect from Medicare and private health insurance.

RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the chief medical director, encourage State homes to collect from veterans receiving pensions an amount equal to the reduction that would occur if the veteran obtained care in a VA facility.

STATE HOME COMMENTS AND OUR EVALUATION

Missouri Veterans' Home

The commandant of the Missouri home said that his home has effectively used and is effectively using the pension and aid and attendance funds to defray the cost of care. (See app. VII.) He said that Missouri paid only 9 percent of the State home costs compared to the other homes' percentages ranging from 49 to 85. According to the commandant, the table on page 43 gives a false picture because it fails to show that the $320 collected from the veterans in Missouri, when added to the VA per diem, represented the total cost of care provided. He said that Missouri law mandates that charges be based on the costs for the "last full fiscal year."

While the Missouri home may not have been able to use the additional $215 retained by the veteran to reduce State costs, the funds could have been used to reduce VA per diem payments.

Soldiers Home in Holyoke

The Massachusetts home's superintendent said that the State can no longer pay such a large share of the home's operating costs, and that VA, the National Association of State Veterans Homes, and the individual States need to develop a reimbursement policy that is fair and equitable not only to these organizations but also to the veterans. (See app. VIII.) He said that in fiscal year 1980 the State paid 70 percent of the home's operating cost with the remaining 30 percent being generated from VA per diem, aid and attendance, Medicare, and private health insurers. According to the commandant, four different systems of charges have been analyzed, none of which would generate any significant amount of revenue. He said that all four systems would be difficult to initiate and would require additional personnel to administer. He said that this is especially difficult today when the home is faced with a reduction in force from 345 authorized positions to 302 positions.

The commandant said that we failed to recognize the effect of budget cuts and collective bargaining problems at the homes. He said that the home will have to absorb $300,000 in collective bargaining costs in fiscal year 1982 and give up $75,000 in equipment requests. He said that, as a result, the home faces the possible layoff of 27 employees and closing of a nursing care unit when there is a waiting list of over 100 veterans who need a nursing home bed.

We believe the home could lessen the effect of budget cuts and collective bargaining costs through veterans' contributions. As we stated in a June 19, 1980, letter to the State's Secretary, Executive Office of Human Services, the home does not collect funds from patients even though authorized by State law to do so.

According to information developed by the home, as of February 29, 1980, there were 253 extended care patients at Holyoke, of whom 251 had monthly incomes. The average income was $443 per month. The potential savings to the Massachusetts home could be as high as $1.15 million a year if the home collects the full amount authorized by the State. In fiscal year 1979, this would have reduced the State's share of the home's operating costs from about 71 percent to about 53 percent.

Washington Soldiers' Home and Colony at Orting
Washington Veterans' Home at Retsil

The superintendents from the two Washington homes said that philosophically they are opposed to charging veterans more for their care. They said that the veterans could not exist on $60 a month because they have to pay for their own clothes, laundry, toiletries, etc.

The Washington homes' superintendents said that the amount of money veterans are allowed to keep is set by law at $172 and that they did not believe the political climate was right to lower it. They said that the State did not have a separate Department of Veterans' Affairs until a couple of years ago, when an attempt was made to put the home under Medicaid, which would have forced them to reduce the veterans' income to $25 a month. The superintendents also said that the opinion of many people is that the Federal Government should pay the total cost of care provided in State homes because "States don't wage war, the Federal Government does."

Veterans obtaining care in VA contract community nursing homes are limited to a pension income of $60 a month. They too pay for their own clothes, laundry, toiletries, etc.

South Carolina War Veterans' Home

The administrator of the South Carolina home believes the per diem paid to the States should remain proportionally constant in relation to the cost of care and should be raised annually.

Veterans' Home of California

The California home's administrator told us that he believes there is a need for a formula system for a more equitable sharing of costs by VA and the States. He said that the Federal responsibility to the veteran is greater than the State's and said that the Federal Government should pay a greater share of State home costs. He said that the problem with the present system is that per diem rates are at least 4 or 5 years behind inflation before they are increased.

The commandant said that the State has taken action to increase revenues from veterans and health insurance. He said that veterans' contributions increased 91 percent from April 1980 to July 1981, that they have tripled the recoveries from Medicare, and that they take veterans' aid and attendance moneys. He said that despite these efforts the State is still paying about 55 percent of the operating costs while VA is paying only about 20 percent.

Although the State has taken action to increase revenues from veterans and health insurance, we believe more could be done. As shown on page 43, the home could obtain an additional $165 a month from a veteran with no dependents by applying the VA pension reduction criteria. In addition, California could, like Massachusetts, pass a law enabling the State home to collect from private health insurers.

Iowa Veterans Home

The Iowa home's commandant said that additional revenues to offset increased State home operating costs should be obtained by increasing the Federal contribution rather than by increasing charges to veterans or recovering costs from health insurance. He said that to obtain additional moneys through Medicare assumes first that the veterans in each State would be eligible and secondly ignores the added necessity of administrative expenses to pursue the additional moneys. He said that State law does not allow the Iowa home to collect from private insurance programs, and that patients pay based on their ability to pay. According to the commandant, the home's patients purchase their own clothing and personal need items and assist with underwriting some of their social activities. He said that the $60 base used by VA has been in effect for years and, with inflation, is no longer appropriate.

The Iowa commandant added:

> "Why become involved in an array of Federal and other programs when it would only require the present method of reimbursement to be changed to meet the needs of the State home program. It would appear more logical to determine a more equitable base for reimbursement with the provision for an annual update of Federal participation. Other Federal programs are updated in terms of participation on an annual basis."

We do not agree that it is more logical to increase VA funding of the State home program than to obtain the needed revenues from other available sources. We believe increased VA funding should be sought only after all other available sources of revenues have been explored and that there should be equal concern about controlling State and Federal spending.

The Iowa home, like the other homes reviewed, could obtain additional revenues from pensions and health insurance. While the Iowa home was charging veterans more than the other eight homes visited, it was charging veterans less than at least seven other homes. (See p. 45.) The success of the California home in recovering costs from Medicare and the Massachusetts home in recovering costs from private health insurance demonstrates the potential for the Iowa home to use these sources of revenues.

Georgia War Veterans Home

The Georgia home's director said that an increase in Federal funding is long overdue, but is a Federal matter. He said that, likewise, whether the Georgia war veteran is charged for services rendered is a matter for the State to determine through its legislative and executive branches. He said that this matter has been considered at the State level in the past and rejected. He said it is reasonable to assume that Georgia State policy is to "help, aid, and assist the war veterans who served their country honorably in time of dire need."

We agree that the ultimate decision as to whether to charge veterans for the care provided in a State home is a State matter. However, veterans at the Georgia home can receive up to about $6,400 a year more in VA pensions than veterans receiving care in a VA or contract community nursing home.

MATTERS FOR CONSIDERATION BY THE CONGRESS

The changes in the method of reimbursing States for care provided in State homes, proposed in H.R. 2832, H.R. 518, and S. 1034, introduced in the 97th Congress, would have increased VA spending by about $25 million in fiscal year 1980 and would likely result in VA paying a larger share of State home costs than would the States in the future. In any deliberations on legislative proposals to change the reimbursement method to increase VA funding, the Congress should consider the extent to which the States are taking advantage of the alternative sources of revenues identified in this chapter.

The Congress should also consider amending 38 U.S.C. 3203 to extend the pension reduction criteria to cover care being furnished in State homes and authorize VA to transfer the money withheld to the States to help pay for the veterans' care.

CHAPTER 6

IMPROVEMENTS NEEDED IN PLANNING

FOR FUTURE USE OF VA, STATE HOME, AND

COMMUNITY NURSING HOME BEDS

Although demand for VA-sponsored nursing home beds is expected to increase by almost 9,200 by 1985 and by over 30,000 by the year 2000, VA has not effectively planned and coordinated the construction or use of VA, State home, and contract community nursing homes to meet the anticipated demands. As a result, VA and State home facilities may be constructed in medical districts already having too many community nursing homes while shortages of nursing home beds are likely in other districts.

DEMAND FOR NURSING HOME BEDS INCREASING RAPIDLY

The number of veterans requiring nursing home care is expected to increase steadily during the next 20 years, reaching over 270,000 by the year 2000. VA expects to provide care to over 54,000 (20 percent) of the veterans through VA, State, and contract community nursing homes.

The Veterans Omnibus Health Care Act of 1976 (Public Law 94-581) directed VA's chief medical director to report on VA's short- and long-range plans for meeting the health care needs of the increasing numbers of aging veterans. VA's plans were contained in an October 1977 report, "The Aging Veteran: Present and Future Medical Needs."

The VA study predicted that veterans will comprise the major portion of the male aged population for the remainder of this century. It stated that

> "At the present time veterans comprise 45 percent of all American males over the age of 20 years. Because of the large number of veterans of World War II and the Korean War, by 1990 more than half of U.S. males over age 65 years will be veterans, and by 1995 veterans will exceed 60 percent of the total * * *."

VA estimated that the demand for nursing home beds would increase by about 50,000 beds between 1980 and 1990 and by another 100,000 by the year 2000. The table below shows the increasing demand for nursing home beds from 1977 to 2000.

Year	Nursing home beds needed for veterans	VA-sponsored nursing home beds needed
1977	99,975	19,995
1980	120,298	24,060
1985	145,817	29,163
1990	170,411	34,082
1995	223,627	44,725
2000	272,483	54,497

Of the veterans provided care under VA sponsorship, VA expects 40 percent to receive care in a VA nursing home, 40 percent in a contract community nursing home, and 20 percent in a State home.

RATIO DOES NOT PROVIDE SOUND BASIS FOR MEDICAL DISTRICT PLANNING

VA divided the demand for nursing home beds in each of its 28 medical districts among VA, contract community, and State nursing homes using the same 40-40-20 ratio applied to the nationwide demand. However, the ratio did not provide a sound basis for medical district planning because it did not approximate the actual ratio in each medical district.

For example, VA provided nursing home care to an average of 502 veterans per day in medical district 2 (comprised of most of New York, four Pennsylvania counties, and one Massachusetts county) during 1979, with 76 percent provided care in a VA nursing home, 16 percent in a contract community nursing home, and 8 percent in a State home. In contrast, only 16 percent of the veterans receiving care in medical district 23 (comprised of most of Iowa and Nebraska, the western half of South Dakota, and parts of Illinois, Kansas, and Wyoming) were provided care in a VA nursing home, while 17 percent were provided care in a community nursing home and 67 percent in a State home.

As shown by the table on the following page, from 16 to 76 percent of the veterans in the 28 medical districts received care in VA nursing homes, from 16 to 72 percent in contract community nursing homes, and from 0 to 67 percent in State homes.

Medical district	Percent of average daily nursing home census provided care by		
	VA	Community	State home
1	31	23	46
2	76	16	8
3	75	25	0
4	25	40	35
5	52	34	14
6	35	65	0
7	42	58	0
8	48	52	0
9	21	35	44
10	59	41	0
11	39	61	0
12	33	67	0
13	54	32	14
14	26	23	51
15	47	29	24
16	35	20	45
17	28	72	0
18	32	52	16
19	55	45	0
20	19	45	36
21	37	43	20
22	34	51	15
23	16	17	67
24	31	41	28
25	42	58	0
26	47	53	0
27	22	32	46
28	20	59	21
All districts	36	39	25

EXCESS FACILITIES MAY BE CONSTRUCTED IN SOME COMMUNITIES

The availability of State and community nursing home beds has not been adequately considered in planning the construction of VA nursing homes. In addition, a suggestion made in our 1972 report that VA determine the need for State nursing homes before approving their construction had not been accepted. VA planned to construct nursing homes in some medical districts that already had too many community and State nursing home beds, and some States planned to construct nursing homes in medical districts where VA's projected need for State nursing home beds had already been exceeded.

VA facilities planned where excess community nursing home beds exist

VA did not always adequately consider the comments of State and local agencies on planned nursing home projects before finalizing its construction plans. As a result, VA plans to construct nursing homes in some communities that already have too many nursing home beds.

Title II of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3334) and title IV of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4231) sought to increase intergovernmental cooperation by giving State agencies, local governments, and other parties the opportunity to review and comment on direct Federal development projects and federally assisted projects (such as State homes). The laws were implemented through Office of Management and Budget Circular A-95. The circular requires that planned Federal development projects be submitted to State and areawide clearinghouses 1/ for review and comment. The primary function of the clearinghouses is to examine proposed projects in relationship to State or areawide plans or policies.

VA obtained comments from State clearinghouses on all 16 nursing home projects planned for construction in fiscal years 1981 and 1982. VA, did not, however, adequately consider the negative comments received on two of the projects--Denver, Colorado, and Coatesville, Pennsylvania. VA planned to construct a 60-bed nursing home in Denver costing an estimated $5.2 million and a 120-bed nursing home in Coatesville costing an estimated $8.5 million.

Planning agencies in the Denver area opposed the construction of the nursing home because too many nursing home beds existed in the area. In a February 8, 1980, letter to VA's assistant chief medical director for planning and program development, the director of project review of the Central-Northeast Colorado Health Systems Agency stated that the Denver area had a surplus of over 2,000 nursing home beds and that health plans for the Denver area project a substantial oversupply of nursing home beds to exist beyond 1984. The letter stated that one of the area's objectives was to reduce the excess nursing home bed capacity by about 1,800 beds by 1984. By March 14, 1980, letter, the executive director, Denver Regional Council of Governments, advised the assistant chief medical director for planning and program development that the council agreed with the health systems agency's comments.

1/State clearinghouses are designated by the Governor and are usually State planning agencies. Areawide clearinghouses are usually comprehensive planning agencies covering one or more counties.

An assistant director in VA central office's Facility Planning Service told us that VA's central office did not respond to the planning agencies' concerns. He said that officials from the Denver VA medical center met with health systems agency officials and attempted to respond to their concerns, but he agreed that VA could have done more to consider the health systems agency's comments.

According to VA's nursing home coordinator, VA tries to justify the construction of VA facilities in areas opposed by clearinghouses. She said that community nursing homes may not be able to meet veterans' needs because they do not always comply with VA standards. However, although VA argues that community facilities cannot be used in lieu of construction of VA nursing homes, it plans to use such community facilities to meet 40 percent of the demand for VA-sponsored nursing home beds in 1985.

Construction of the Coatesville nursing home was opposed by the Health Systems Agency of Southeastern Pennsylvania in June 1979 comments because the community already had enough nursing home beds. The comments stated that, under the existing health systems plan, no more beds were needed. It further noted that determining what effect the VA nursing home would have on the occupancy rate of existing nursing homes was impossible.

In a September 25, 1979, letter to the Delaware Valley Regional Planning Commission, VA advised the commission that it routinely conducted nationwide demographic studies to determine the location and types of health care facilities and services that will best meet the changing requirements of veterans, while attempting to address the health care needs of the general community. VA's demographic data did not, however, determine the availability of community nursing home beds in the Coatesville area.

Availability of State home facilities
not considered in planning VA facilities

VA did not consider the availability of State home facilities in planning for the construction of VA nursing homes. As a result, VA nursing homes are planned in some medical districts where existing and planned State home beds are adequate to meet VA's anticipated needs.

According to VA's assistant chief medical director for planning and program development, the demographic and geographic aspects of State homes were not considered in planning for the construction of VA facilities. His facility planning service director told us that he coordinates VA construction plans to see that the projects are within budget constraints, but does not consider State home construction in developing VA's 5-year facility plan. The program planning and development director told us that he does not consider State homes in developing his program plans.

Both VA and State nursing homes are planned in Minneapolis, and Boise. VA plans to construct an 845-bed medical center in Minneapolis, including 120 nursing home beds, to replace the existing acute-care facility. Minnesota opened a 250-bed nursing home at the State home in 1981 and notified VA of its plans to construct an additional 250 beds at the home in 1983. The home is located near the Minneapolis VA medical center. The State has not yet applied for a VA construction grant for the 1983 project, and, according to VA's State home coordinator, VA has no assurance that it will be constructed.

The Metropolitan Health Board, the health planning agency for the Minneapolis-St. Paul metropolitan area, said that the area has an oversupply of nursing home beds and that VA has had no problem in meeting its nursing home care needs through use of community nursing homes. The board recommended that the replacement medical center be limited to 40 nursing home beds.

Both VA and Idaho plan to operate nursing homes in Boise. The State completed construction of an 80-bed nursing home at the State home during 1981. VA plans to construct a 60-bed nursing home in Boise in 1983 at a cost of about $6 million. According to VA's State home and nursing home coordinators, VA did not determine whether the State home beds could have been used in lieu of constructing the VA nursing home.

Need for planned State home facilities not assessed

Although we suggested in our 1972 report that the Administrator determine the need for State home facilities before approving grants for their construction, VA has continued to approve grants without determining whether the project is needed. Applications for construction of State nursing homes have been approved or are pending in two medical districts that have enough VA and State home beds to meet the VA-projected nursing home needs through 1985.

In our 1972 report we stated that only projects justified on the basis of need should be undertaken. We suggested that each proposal for construction of a nursing home under the State home program be supported by meaningful data regarding the need for the facility and that VA fully evaluate such data before approving a grant.

According to VA's State home coordinator, however, no evaluation of the need for a State home facility is made when a construction grant application is received. She said that VA awards construction grants in the order in which applications are received, subject only to the availability of funds.

VA's assistant chief medical director for extended care told us that VA has no legal authority to assess the need for State home beds. He said that VA does not determine the need for State home facilities because it has no choice by law other than to approve a State home grant application if the State meets all the requirements established by the Administrator. Further, he said that the need for a State home is determined by the State.

We believe, however, that the law requires VA to make a determination of need before approving State home construction grants. VA is required to establish, by regulation, the "* * * number of beds required to provide adequate nursing home care to veterans residing in each State." (38 U.S.C. 5034(1)). And 38 U.S.C. 5035(b) states that the Administrator shall approve any grant application if, among other things,

> "* * * the construction of such project, together with other projects under construction and other facilities, will not result in more than the number of beds prescribed by the Administrator pursuant to section 5034(1) of this title for the State in which such project is located being available for furnishing nursing home care to veterans in such State."

Nebraska plans to construct a 50-bed State nursing home in medical district 23 although the district already has more State nursing home beds than VA predicts will be needed to meet the total need for VA-sponsored nursing home beds through 1985. As of December 1980, the district had 1,363 State nursing home beds. VA anticipates providing care to only about 652 veterans per day in the medical district by 1985, including care provided in VA, contract community, and State nursing homes. Thus, without considering the availability of VA and community nursing home beds, twice as many nursing home beds will be available than will be needed. Yet, as of July 1981, an application for construction of a 50-bed State nursing home in Scottsbluff was pending approval.

Similarly, in medical district 1 VA approved Maine's application for construction of a 200-bed State nursing home although there were enough VA and State nursing home beds in the district to meet the estimated need for VA-sponsored nursing home beds through 1985. VA estimates that in 1985 it will provide nursing home care to 1,338 veterans per day through VA, State, and community nursing homes in the district. As of December 1980 there were 522 VA and 847 State nursing home beds in the district--31 more than VA projects it will need.

In February 1980, VA awarded a $3.8 million grant to Maine to construct a 200-bed nursing home. Construction of the facility has been delayed, however, because the State's commissioner of human services refused to issue a certificate of need for the facility.

However, construction of 110 other VA and State nursing home beds is planned in the district by 1985. VA plans to construct a 60-bed nursing home in Providence, Rhode Island, in 1984 at an estimated cost of $6.5 million. And Vermont has applied for a grant to construct a 50-bed State nursing home in 1982 at an estimated cost to VA of $3.25 million. According to VA's State home coordinator, funding for the Vermont project will probably be available in fiscal year 1984.

If all three nursing homes are constructed, VA and State nursing home beds will exceed VA's 1985 needs in the district by over 300 beds.

States in four other medical districts that have more State nursing home beds than VA expects to need in 1985 have notified VA that they plan to construct more nursing home beds by 1985. In two districts, planned and existing VA and State home beds are about equal to VA's predicted 1985 nursing home care needs.

SOME MEDICAL DISTRICTS MAY HAVE SHORTAGE OF NURSING HOME BEDS BY 1985

Although VA plans to provide care to 60 percent of the VA-sponsored nursing home patients through the use of State home and contract community nursing homes, VA had not taken effective action to insure the availability of such facilities. Most States in medical districts that have no State nursing homes do not plan to construct such facilities by 1985, and shortages of community nursing home beds exist in other medical districts. Because VA has not planned for the construction of VA facilities to compensate for the anticipated shortage of State home and community facilities, VA may be unable to provide nursing home care to all eligible veterans living in those districts.

Shortages of State home beds will exist in some medical districts

Although VA plans to meet 20 percent of the demand for VA-sponsored nursing home beds in each medical district through the use of State home facilities, 11 of the 28 VA medical districts have no State nursing home beds. VA estimates it will need 2,544 State nursing home beds in the 11 medical districts that have no State homes. Construction of State nursing home beds is being considered in only two of the districts, and enough VA nursing home beds will not be available to compensate for the lack of State home beds. Unless VA is able to contract for additional community nursing home beds, an acute shortage is likely. However, as discussed on pages 59 and 60, adequate community nursing home beds may not be available in some medical districts.

Each year, VA asks State officials to provide 5-year plans for the construction of State home facilities. In 1980, States in only 2 of the 11 medical districts advised VA of their intent to construct nursing home beds by 1985. Those two projects would add only 150 of the over 2,500 beds needed.

VA's State home coordinator told us that VA contacts all States annually to determine if they plan to participate in the State home program, but does not attempt to "sell" the program to the 16 nonparticipating States. Nor, according to the State home coordinator, does VA discuss its long-range plans for use of State home beds with States.

VA's assistant chief medical director for extended care told us that, beginning with establishment of the construction grant program in 1964, requirements for admission to the State home program were established in such a fashion that States were encouraged to participate in the program under the least requisite amount of documentation and "red tape." He said that VA has helped the States construct over 6,000 nursing home beds since the program was established, enabling thousands of veterans to obtain quality care at bargain rates.

Officials from the 14 1/ nonparticipating States we contacted were aware of the State home program and were generally interested in future participation. Officials in 9 States cited problems in getting approval from the State legislature for the State's 35-percent share of the construction costs. Other reasons cited included the lack of an active veterans' group lobbying for establishment of a State home, politics, and a belief that caring for veterans is the Federal Government's responsibility.

None of the 11 medical districts will have enough VA nursing home beds to compensate for the shortage of State home beds, and in five medical districts, a shortage of VA nursing home beds by 1985 is projected.

Enough community nursing home beds may not be available

Although VA plans to rely heavily on contract community nursing home beds to meet the needs of aging veterans, it has done little to assure the availability of such beds. VA plans to use community nursing homes to meet 40 percent of the 1985 demand for VA-sponsored nursing home care in each medical district. Officials from two of the three medical districts where VA's need for community nursing home beds will be greatest told us that they will be unable to meet VA's needs.

1/We did not contact officials from Alaska or Hawaii.

According to VA's community nursing home coordinator, he had not contacted local communities about VA's future needs for nursing home beds. He said that he does not work with health systems agencies and believes that VA will have no trouble getting community nursing home beds because VA's current use of community beds is a very small percentage of available beds.

We contacted health planning officials in medical districts where VA will need to contract for over 1,000 community nursing home beds in 1985. In medical district 26, comprised of southern California and one Nevada county, the California State clearinghouse advised us that VA had not notified it of proposed contracting for nursing home beds. The California Statewide Health Facilities and Services Plan for 1980-85 projected a shortage of about 3,400 skilled and intermediate nursing home beds by 1985 in the southern California counties included in medical district 26. An official from the San Diego health systems agency told us that there is a shortage of community nursing home beds in the area and that there are long waiting lists.

A health systems agency official in medical district 12, comprised of most of Florida and southern Georgia, told us that there were shortages of community nursing home beds in Florida's major metropolitan areas. By December 4, 1980, letter, the acting director, cooperative health statistics system in the State's Office of Health Planning and Development, provided statistics showing that almost 2,000 persons were on waiting lists for nursing home care in five Florida counties, including the Tampa/St. Petersburg and Miami metropolitan areas, as of December 1980. About 1,250 additional nursing home beds have been approved for construction in the counties through December 1981. The acting director said he could not project the beds needed or planned for construction beyond December 1981.

Community nursing home beds appear adequate to meet VA's needs in medical district 3 (comprised of metropolitan New York City, Connecticut, two counties in Massachusetts, and Puerto Rico). The deputy director, Office of Health Systems Management, State of New York Department of Health, advised us by November 3, 1980, letter that enough nursing home beds to meet VA's needs will be available within New York City by 1982. He said that the projected needs developed by his office are population based and therefore include veterans. We did not determine the availability of community nursing home beds in the rest of the district.

CONCLUSIONS

Because VA has not effectively planned and coordinated the construction and/or use of VA, State home, and contract community nursing homes, VA and State home facilities may be constructed in areas already having too many community nursing home beds while

not enough nursing home beds may be available in other areas to meet VA's anticipated needs.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the chief medical director:

- --Establish, in coordination with State and local planning agencies, and the National Association of State Veterans Homes, more realistic medical district plans for the construction and/or use of VA, community, and State nursing homes to provide care to veterans.
- --Determine the need for State home construction projects before approving their construction.

STATE HOME COMMENTS

Iowa Veterans Home

The Iowa home's commandant said that it will be difficult to develop a standardized approach to planning because VA's medical districts cut across several States. He said, however, that State homes could be consulted and this provides some continuity with long-range planning.

Veterans' Home of California

The California home's administrator agreed with our recommendation that VA assess the need for State homes before awarding construction grants and said that VA's first-come-first-served policy has to end. He said that, under the current policy, States that already have four new homes can get money to build a fifth home while another State which has an older home with fire and safety defects has to wait for funding.

OBJECTIVES, SCOPE, AND METHODOLOGY

In fiscal year 1980 State homes provided hospital, nursing home, and domiciliary care to an average of over 11,000 veterans a day. Because the Senate Committee on Veterans' Affairs had limited information on the program, Senator Alan Cranston, as Committee Chairman, requested that we determine whether (1) homes were capable of providing quality care, (2) Federal support of the program was adequate, and (3) VA was effectively administering the program.

To accomplish this, we visited nine homes in eight States; VA's central office in Washington, D.C.; and the eight VA medical centers responsible for administering the program at the nine homes. The review work was performed at the homes between March and September 1980. The homes and corresponding VA medical centers reviewed, and the levels of care provided, were as follows:

Home	Levels of care provided: Domiciliary	Nursing home	Hospital	VA medical center
Veterans' Home of California	x	x	x	San Francisco, CA
Connecticut Veterans' Home and Hospital	x		x	Newington, CT
Georgia State War Veterans' Home at Milledgeville	x	x		Dublin, GA
Iowa Veterans' Home	x	x	x	Des Moines, IA
Soldiers' Home in Holyoke (MA)	x	x	x	Northhampton, MA
Missouri Veterans' Home	x	x		St. Louis, MO
South Carolina War Veterans' Home		x		Columbia, SC
Washington Soldiers' Home and Colony at Orting	x	x		Seattle, WA
Washington Veterans' Home at Retsil	x	x		Seattle, WA
	8	8	4	

The homes were selected to provide a geographic representation and to include homes that differ in the levels of care provided, the age of the facilities, and the level of State financial support. The selection was coordinated with VA, the staff of the Senate Committee on Veterans' Affairs, and the president of the National Association of State Veterans' Homes. 1/

At each home we interviewed officials and reviewed records concerning the types of programs and services provided, level of care placement criteria and decisions, the costs of operations, and the need for additional VA funding. At the VA medical centers we interviewed the directors, State home inspectors, and certifying physicians and reviewed records and regulations concerning the medical center's role in monitoring the care provided, insuring the accuracy of VA per diem payments, and assessing compliance with standards.

ASSESSMENT OF HOMES' CAPABILITY TO PROVIDE QUALITY CARE

We did not attempt to determine whether the State homes we visited were providing quality care. However, with the assistance of our chief medical advisor, we assessed the homes' capability to provide quality care.

According to the National Academy of Sciences, quality of care can best be described as a multidimensional set of attributes that can be assessed by examining three broad facets: the structure, the process, and the outcome of medical care. "Structure" refers to the inputs to care, such as facilities, staff, and equipment; "process," to what happens between provider and patient (i.e., the act of care-giving); and "outcome," to the effects on the patient's health status resulting from the care given.

In our review, we attempted to determine the homes' capability to provide quality care by assessing the structure and process of care provided. However, we did not attempt to assess the effects on the patients' health that resulted from the care. Thus, no conclusions can be drawn about the quality of care actually provided.

Our assessments of the structure of care were based on (1) observations on the cleanliness and physical condition of the homes, the dress and grooming of patients, and the involvement of

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1/An association of officials from State homes and the State agencies responsible for their operation, which represents the homes in presenting matters to the Congress, establishes standards of care, and acts as a clearinghouse for techniques and expertise in the care of veterans and the management of State institutions.

patients in recreational and other activities, (2) our medical advisor's review of profile data we developed on each home, including data on the home's staff, facilities, and services (see p. 20), and (3) inspections of State home facilities by JCAH, HHS, and State agencies.

Our assessments of the process of care were limited to reviewing the medical records of a random sample of 30 veterans at each home to determine whether patient needs were being identified and whether care was properly documented in the patients' medical records. The criteria used were based on VA State home standards of care. We examined the records to determine whether

--hospital patients received daily and nursing home patients monthly physician visits;

--hospital patients received a physical examination within 24 hours of admission, nursing home patients within 48 hours, and domiciliary residents received an admission physical;

--nursing home and domiciliary patients received annual physicals;

--domiciliary patients received annual dental examinations;

--social histories were prepared;

--social plans of care were established for nursing home and hospital patients;

--physicians' orders were signed for domiciliary residents and verbal orders were signed within 24 hours for nursing home and 48 hours for hospital patients;

--progress notes were written and signed by a physician at the time of each visit;

--medication charts for nursing home patients were reviewed monthly by a physician;

--nursing plans of care were prepared;

--rehabilitation plans of care were prepared and monthly progress notes were recorded; and

--therapeutic diets were prescribed by a physician.

Because of the small numbers of records reviewed at each home, the results cannot be statistically projected to the homes' populations.

ASSESSMENT OF VA PROGRAM ADMINISTRATION

To assess the effectiveness of VA's administration of the State home program, we reviewed VA's efforts to

--verify the levels of care needed by veterans admitted to State homes;

--establish standards of care for and inspect State homes;

--plan and coordinate the construction of State, VA, and community nursing homes; and

--encourage nonparticipating States to join the State home program.

To determine if veterans were placed at the proper level of care, we reviewed the VA medical centers' procedures for certifying the placement decisions made by the homes, and our medical advisor reviewed the medical records of random samples of hospital patients at the California and Connecticut homes and hospital, nursing home, and domiciliary patients at the Iowa home to find out whether their medical conditions justified the level of care certified. We also discussed the homes' placement decisions with VA and home officials. The table below shows the size of our samples at the three homes:

Home	Universe	Sample size	Date of sample
California hospital	319	81	July 7, 1980
Connecticut hospital	302	86	July 17, 1980
Iowa:	541	80	July 8, 1980
Hospital	(116)	(19)	
Nursing home	(314)	(45)	
Domiciliary	(111)	(16)	

The sample results were statistically projected to the universe at the 95-percent confidence level with an error rate not varying by more than 11 percent. The Iowa sample was not projected by level of care because the samples were too small.

To determine whether VA State home standards were comparable to standards developed by JCAH and HHS and whether VA's inspection program had been implemented effectively, we

--discussed the development of the standards with VA officials;

--compared VA's nursing home and hospital standards to those used by JCAH and HHS, and the domiciliary standard to unpublished criteria for VA domiciliaries;

--obtained the views of State home officials on the adequacy and appropriateness of VA's standards;

--analyzed VA's fiscal year 1979 State home inspection reports and supporting documentation to find out whether compliance with all standards had been assessed and whether the results were accurately reported;

--discussed 80 of VA's State home standards with inspectors from eight VA medical centers to find out what criteria they used to assess compliance with the standards; and

--reviewed VA central office's followup on inspection reports.

We did not review the VA State home domiciliary standards in detail because JCAH and HHS do not have domiciliary standards. However, except for laboratory services, they address the same areas covered in the hospital and nursing home standards.

To determine whether VA had effectively planned for and coordinated the construction and/or use of VA, State, and contract community nursing homes to meet the extended care needs of aging veterans, we interviewed VA officials; compared the VA-estimated 1985 nursing home needs in each medical district to existing and planned VA, State home, and community nursing home beds; and contacted officials from health systems agencies (local health planning bodies) to determine the availability of community nursing home beds in selected medical districts where VA or State nursing home construction is planned or where shortages of VA and State nursing home beds are expected.

To determine whether VA could have done more to encourage participation in the State home program, we asked VA officials what steps they took to increase the number of participating States and contacted officials in States not participating in the State home program (except Alaska and Hawaii) to find out why.

ASSESSMENT OF ADEQUACY OF FEDERAL SUPPORT

To determine whether the per diem method used to help the States defray costs of care provided to veterans should be changed, we (1) interviewed State home officials to identify problems the present per diem system may have caused, (2) determined how homes were using available funding sources, (3) reviewed the legislative history of the per diem program, and (4) analyzed three proposals for changing the current reimbursement method to find out whether they would increase VA costs and how they would affect VA's share of State home costs.

PER DIEM PAYMENTS FOR DOMICILIARY, NURSING HOME, AND

HOSPITAL CARE PROVIDED BY HOMES DURING FISCAL YEAR 1980

Location of State home	Costs shared by VA and State homes				Per diem payments	
	Veteran days of care	Average daily census (note a)	Per diem cost (note b)	Total veteran cost	By VA (note c)	Percent of total cost (note d)
Domiciliary care:						
Little Rock, AR (note e)	610	7.7	$142.85	$ 87,139	$ 3,355	3.9
Yountville, CA	216,271	590.9	17.91	3,873,414	1,189,491	30.7
Florence, CO	-	-	-	-	-	-
Homelake, CO	25,545	69.8	17.39	444,228	140,498	31.6
Rocky Hill, CT	152,908	417.8	17.47	2,671,303	840,994	31.5
Occoquan, DC	47,551	129.9	31.00	1,474,081	261,531	17.7
Augusta, GA	-	-	-	-	-	-
Milledgeville, GA	87,669	239.5	f/47.69	4,180,935	482,180	11.5
Boise, ID	41,548	113.5	12.33	512,287	228,514	44.6
Quincy, IL	33,145	90.6	26.06	863,759	182,298	21.1
Lafayette, IN	30,495	83.3	24.48	746,518	167,723	22.5
Marshalltown, IA	35,810	97.8	32.65	1,169,197	196,955	16.8
Ft. Dodge, KS	20,076	54.9	14.52	291,504	110,418	37.9
Jackson, LA	39,801	108.7	33.61	1,337,712	218,906	16.4
Chelsea, MA	95,699	261.5	17.12	1,638,367	526,345	32.1
Holyoke, MA	12,431	34.0	22.80	283,427	68,371	24.1
Grand Rapids, MI	56,877	155.4	19.22	1,093,176	312,824	28.6
Hastings, NE	48,927	133.7	24.36	1,191,862	269,099	22.6
Minneapolis, MN	122,066	333.5	15.76	1,923,760	671,363	34.9
St. James, MO	20,760	56.7	18.80	390,288	114,180	29.3
Columbia Falls, MT	25,017	68.4	17.46	436,797	137,594	31.5
Grand Island, NE	50,453	137.8	26.30	1,326,914	277,492	20.9
Tilton, NH	-	-	-	-	-	-
Menlo Park, NJ	31,739	86.7	20.72	657,632	174,565	26.5
Vineland, NJ	12,606	34.4	40.97	516,468	69,333	13.4
Oxford, NY	15,628	42.7	48.32	755,145	85,954	11.4
Lisbon, ND	37,816	103.3	16.24	614,132	207,988	33.9
Sandusky, OH	183,205	500.6	17.52	3,209,752	1,007,628	31.4
Ardmore, OK	35,779	97.8	22.30	797,871	196,785	24.7
Clinton, OK	10,105	27.6	29.43	297,390	55,578	18.7
Norman, OK	63,723	174.1	39.80	2,536,175	350,477	13.8
Sulphur, OK	10,069	27.5	29.58	297,841	55,380	18.6
Talihina, OK	-	-	-	-	-	-
Erie, PA	26,139	71.4	27.28	713,072	143,765	20.2
Hollidaysburg, PA	23,407	64.0	58.79	1,376,098	128,739	9.4
Bristol, RI	33,001	90.2	28.58	943,169	181,506	19.2
Columbia, SC	-	-	-	-	-	-
Hot Springs, SD	31,170	85.2	20.24	630,881	171,435	27.2
Bennington, VT	4,805	13.1	20.71	99,512	26,428	26.6
Orting, WA	26,630	72.8	32.97	877,991	146,465	16.7
Retsil, WA	50,804	138.8	26.65	1,353,927	279,422	20.6
King, WI	11,025	30.1	26.65	293,816	60,638	20.6
Buffalo, WY	16,376	44.7	32.81	537,297	90,068	16.8
Total	1,787,686	4,884.4	$23.74	$42,444,837	$9,832,285	23.2

Location of State home	Veteran days of care	Average daily census (note a)	Per diem cost (note b)	Total veteran cost	Per diem payments: By VA (note c)	Per diem payments: Percent of total cost (note d)
	Costs shared by VA and State homes					
Nursing home care:						
Little Rock, AR	-	-	$ -	$ -	$ -	-
Yountville, CA	118,288	323.2	23.85	2,821,169	1,242,024	44.0
Florence, CO	40,182	109.8	32.10	1,289,842	421,911	32.7
Homelake, CO	5,696	15.6	32.56	185,462	59,808	32.2
Rocky Hill, CT	-	-	-	-	-	-
Occoquan, DC	-	-	-	-	-	-
Augusta, GA	64,936	177.4	35.27	2,290,293	681,828	29.8
Milledgeville, GA	54,450	148.8	f/61.47	3,347,042	571,725	17.1
Boise, ID	-	-	-	-	-	-
Quincy, IL	110,528	302.0	43.57	4,815,705	1,160,544	24.1
Lafayette, IN	58,645	160.2	45.40	2,662,483	615,773	23.1
Marshalltown, IA	101,116	276.3	41.59	4,205,414	1,061,718	25.2
Ft. Dodge, KS	19,200	52.5	32.25	619,200	201,600	32.6
Jackson, LA	-	-	-	-	-	-
Chelsea, MA	19,872	54.3	28.40	564,365	208,656	37.0
Holyoke, MA	86,088	235.2	55.30	4,760,666	903,924	19.0
Grand Rapids, MI	191,104	522.1	46.79	8,941,756	2,006,592	22.4
Hastings, NE	-	-	-	-	-	-
Minneapolis, MN	30,240	82.6	38.58	1,166,659	317,520	27.2
St. James, MO	37,049	101.2	27.59	1,022,182	389,015	38.1
Columbia Falls, MT	13,825	37.8	31.37	433,690	145,163	33.5
Grand Island, NE	132,175	361.1	35.59	4,704,108	1,387,838	29.5
Tilton, NH	33,234	90.8	34.08	1,132,615	348,957	30.8
Menlo Park, NJ	93,088	254.3	27.22	2,531,678	977,424	38.6
Vineland, NJ	89,051	243.3	45.96	4,092,784	935,036	22.8
Oxford, NY	16,483	45.0	69.22	1,140,953	173,072	15.2
Lisbon, ND	-	-	-	-	-	-
Sandusky, OH	89,041	243.3	25.75	2,292,806	934,931	40.8
Ardmore, OK	28,240	77.2	36.01	1,016,922	296,520	29.1
Clinton, OK	54,769	149.6	40.26	2,205,000	575,075	26.1
Norman, OK	16,600	45.4	40.36	669,976	174,300	26.0
Sulphur, OK	47,423	129.6	43.84	2,079,024	497,942	24.0
Talihina, OK	54,507	148.9	45.74	2,493,150	572,324	23.0
Erie, PA	25,419	69.5	68.37	1,737,897	266,900	15.4
Hollidaysburg, PA	13,459	36.8	92.52	1,245,227	141,320	11.3
Bristol, RI	85,238	232.9	43.36	3,695,920	894,999	24.2
Columbia, SC	39,926	109.1	35.12	1,402,201	419,223	29.9
Hot Springs, SD	10,761	29.4	40.23	432,915	112,991	26.1
Bennington, VT	44,851	122.5	34.43	1,544,220	470,935	30.5
Orting, WA	30,395	83.0	49.51	1,504,856	319,148	21.2
Retsil, WA	27,992	76.5	48.80	1,366,010	293,916	21.5
King, WI	160,707	439.1	43.84	7,045,395	1,687,424	24.0
Buffalo, WY	-	-	-	-	-	-
Total	2,044,578	5,586.3	$40.81	$83,459,585	$21,468,076	25.7

Location of State home	Veteran days of care	Average daily census (note a)	Per diem cost (note b)	Total veteran cost	Per diem payments: By VA (note c)	Per diem payments: Percent of total cost (note d)
	Costs shared by VA and State homes					
Hospital care:						
Yountville, CA	121,092	330.9	$ 46.60	$ 5,642,887	$ 1,392,558	24.7
Rocky Hill, CT	116,656	318.7	62.67	7,310,832	1,341,544	18.4
Quincy, IL	9,199	25.1	69.30	637,491	105,789	16.6
Marshalltown, IA	40,235	109.9	85.79	3,451,761	462,703	13.4
Chelsea, MA	41,373	113.0	148.15	6,129,410	475,790	7.8
Holyoke, MA	3,082	8.4	210.18	647,775	35,443	5.5
Sulphur, OK	7,403	20.2	61.46	454,988	85,135	18.7
King, WI	1,010	2.8	199.46	201,455	11,615	5.8
Total	340,050	929.0	$ 71.97	24,476,599	3,910,577	15.9
Grand Total	4,172,314	11,399.7		$150,381,021	$35,210,938	

a/Average daily census is equal to the veteran days of care divided by 366 (number of days in FY 1980).

b/Per diem cost is based on the total cost of operation divided by the total days of patient (veteran/nonveteran) care during fiscal year.

c/Totals unaudited by VA.

d/VA percent of total cost is based on total veteran cost divided by the VA per diem payments.

e/Payments began effective 7/14/80.

f/The Georgia home's director said that the per diem costs are considerably lower than shown because the State's bookkeeping system does not accurately track indirect costs.

Source: VA Central Office.

CONSTRUCTION GRANTS TO STATE HOMES

As of September 30, 1980, VA had made commitments for construction and renovation grants and obligated funds for the following projects:

Location	Number of projects (note a)	Number of new beds	Total estimated cost	Actual VA commitments/ obligation
			(000 omitted)	
Ardmore, OK	1	-	$ 48	$ 31
Augusta, GA	1	192	1,956	978
Augusta, ME	1	200	6,000	3,840
Bennington, VT	5	135	5,590	2,888
Boise, ID	2	90	2,223	1,368
Bristol, RI	2	315	4,611	2,891
Buffalo, WY	2	60	2,786	1,811
Chelsea, MA	15	-	5,119	2,825
Clinton, OK	3	36	758	471
Columbia Falls, MT	1	40	449	220
Columbia, SC	1	115	1,982	687
Erie, PA	3	75	3,236	1,861
Florence, CO	1	120	1,331	865
Ft. Dodge, KS	1	88	830	415
Grand Island, NE	3	200	3,299	1,333
Grand Rapids, MI	1	537	7,689	3,702
Hastings, MN	1	-	1,969	1,279
Hollidaysburg, PA	2	412	5,361	3,379
Holyoke, MA	10	155	2,849	1,354
Homelake, CO	4	-	487	314
Hot Springs, SD	1	-	42	27
Jackson, LA	1	235	8,675	5,000
King, WI	9	400	7,264	3,337
Lafayette, IN	2	250	12,532	6,126
Lisbon, ND	2	-	1,781	1,158
Little Rock, AR	1	150	1,663	1,081
Marshalltown, IA	16	620	23,827	14,639
Menlo Park, NJ	4	200	5,187	2,696
Milledgeville, GA	2	132	5,849	2,626
Minneapolis, MN	5	250	7,467	4,848
Norman, OK	2	50	492	246
Orting, WA	11	40	4,382	2,831
Quincy, IL	2	200	3,401	1,785
Retsil, WA	8	78	5,236	3,384
Rocky Hill, CT	4	-	1,463	947
St. James, MO	2	60	1,569	858
Sandusky, OH	1	300	9,795	6,179
Scotts Bluff, NE	1	-	618	402
Sulphur, OK	1	-	107	69
Tilton, NH	2	100	2,516	1,485
Vineland, NJ	4	300	8,131	3,279
Yountville, CA	7	-	1,920	1,248
Total	148	6,135	$172,490	$96,763

a/All projects do not involve new beds. Projects for renovation and alteration of existing facilities are eligible for construction grants under 38 U.S.C. 5031.

Source - VA Central Office.

Iowa Department of Social Services

IOWA VETERANS HOME

MARSHALLTOWN, IOWA 50158
515-752-1501

September 4, 1981

ROBERT D. RAY
GOVERNOR

MICHAEL V. REAGEN
Commissioner

JACK J. DACK
Commandant

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting
  Office
Washington, D.C. 20548

Dear Mr. Ahart:

In response to the draft of the proposed report, State Veterans Home: "Opportunities to Reduce Veterans Administration and State Costs and Improve Program Management," received August 24, 1981, I wish to make the following comments:

In reviewing the letter of Senator Cranston to Comptroller General of the United States, Elmer B. Staats, I find no where a request for an investigation of the State Veterans Home Program for ways of reducing costs. The thrust of the draft seems to picture a regressive approach to providing a quality of life for patients within the State Veterans Home Program. Emphasis seems not placed on the best utilization of patient resource needs, but whether they fit a strict classification system. The enthusiasm for entering the program by new states will surely be dampened by the thoughts and opinions expressed in this document, particularly in the area of Federal support. Not only does it seem overly critical of both the Veterans Administration and the State Veterans Home Program, but what positive attributes that exist are written in such a manner that the effect is reduced. For example, Page vii - State Homes are Capable of Providing Primarily Nursing Home and Domiciliary Care - "State Homes are capable of providing quality nursing home and domiciliary care to their patients, but only limited acute care capabilities. The quality of care provided in the eight State Homes providing nursing home care included in the General Accounting Office's review <u>was at least comparable to that provided in most community nursing homes</u>."* We, at the Iowa Veterans Home, feel we provide care for patients beyond the scope of the community nursing homes. Our admissions reflect the increased need for the many health care services which we provide.

IOWA COUNCIL ON SOCIAL SERVICES

Joan Lipsky (Cedar Rapids) | Gracie Larsen (Ames) | Dolph Pulliam (Des Moines) | Fernice Robbins (Waverly) | Madalene Townsend (Davenport)

I take exception to the statement that "about one-third of the patients for whom the Veterans Administration was paying nursing home rates at the Iowa Veterans Home needed only domiciliary care." This is a statement of opinion by one individual, based on a brief review of charts and a one-day visit to the Facility. It is one thing to read a record and briefly observe patients; however, it is another to have a working knowledge of patients functioning in regard to the level of care placement, keeping in mind the patient's total needs for care. After all of the discussion pertinent to particular patients in the Iowa Home, it seems minimal importance was given to the total care concept for the Veterans, involving the psycho-social and physical level of functioning.

Yes, our Domiciliary staffing indicates a higher Social Worker staff-to-patient ratio than nursing care level. Intense work with those Residents have assisted in maintaining them in the Domiciliary; otherwise, they would have been in a more structured setting - nursing care. Our FY 1980 domiciliary costs indicate a higher per diem than that of the Veterans Administration in the same level of care.

It is interesting to note in the Thursday, August 27, 1981 issue of "Stars and Stripes," that the Veterans Administration is testing a "multi-level care system" where the patient resource needs, and not diagnosis, dictate levels of care. I submit the professional staff of the Iowa Veterans Home and the Veterans Administration are duly qualified to recommend and approve an appropriate level of care.

We have never considered the "hospital care" offered at the Iowa Veterans Home as acute. Nowhere in the definition of hospital care in the State Home Manual can the word "acute" be found. However, I definitely feel we provide an "intermediate" level of hospital care. Our Physicians do make daily rounds and we do have and provide the necessary attendant services for such care.

The State Veterans Home Program needs additional revenues to offset increases in operating costs. The draft recommendation was that the increase cost of care could be probably borne to a greater extent by the Veterans, private health insurance and Medicare. To obtain additional monies through Medicare assumes, first, that the Veterans in each state would be eligible; and, secondly, ignores the added necessity of Administrative expense to pursue these additional monies. State law does not allow us, as a State Institution, to collect from private insurance programs and we do consider that patients pay on their ability to pay, based on income and assets. Why become involved in an array of Federal and other programs when it would only require the present method of reimbursement be changed to meet the needs of the State Home Program. It would appear more logical to determine a more equitable base for reimbursement with the provision for an annual update of the Federal participation. Other Federal programs are updated in terms of participation on an annual basis.

The National Association of State Veterans Homes' pending legislation provides the mechanism and language to meet this need. Patients at the Iowa Veterans Home purchase their own clothing, personal need items and assist with underwriting some of their social activities. The sixty dollars base, as recommended, has been established for years; and, with the inflation rate and current cost of living factors, is no longer appropriate.

To effect Standards of Care and have uniform assessment within the State Home program is going to require time and continued training on the part of the reviewers. We, in Iowa, believe Standards of Care are important in the delivery of care services; but, at the same time, increases in staffing costs dollars. It is our contention these increased costs be shared on a more equitable basis by the Federal Government.

Since the initiation of the Standards of Care in 1979, I feel the review personnel from the Veterans Administration Clinic of Jurisdiction have demonstrated interest, concern and a willingness to meet their obligation, as well as be of assistance to the State Home.

It has been said that Government has never been able to obtain unity among the States. I believe this holds true for the State Veterans Home Program. It is State-administered with different rules and regulations in each State which determine each Home's operation. To standardize the planning for needed beds will be difficult from this point of view. Each State is an entity into itself with the Home serving, in most instances, Veterans within its boundaries. Admission and residency requirements vary from State to State. To enter the State Veterans Home Program or expand existing programs depends upon the graciousness of a State toward its sons and daughters who have answered their Nation's call. The Medical Districts cut across several States; thus, it will be difficult to develop a standardized approach. It is, however, felt the State Veterans Home could be consulted; thus, provide some continuity with long range planning.

I appreciate the opportunity to respond to the comments in the draft proposal.

Sincerely,

Jack J. Dack, Commandant

JJD/rg

* Underlining that of the writer.

STATE OF CONNECTICUT

VETERANS HOME AND HOSPITAL
DEPARTMENT OF HEALTH SERVICES
287 West Street
Rocky Hill, Connecticut 06067

Telephone (203) 529-2571

September 10, 1981

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

My staff and I have reviewed the GAO draft report on State Veterans Homes and Hospitals and found it to be objective, informative and essentially accurate in its findings and recommendations.

However, I welcome this opportunity to respond to that draft since, in one significant area - certifying level of care - I disagree with the report.

The GAO staff was constrained to VA Manual M-1 definitions of levels of care. As a result, patients were either hospital (which means "acute hospital") or nursing home level.

Our hospital is licensed by the State and accredited by Joint Commission on Accreditation of Hospitals as a 350 bed facility. Specifically, we operate 50 acute and 300 chronic beds.

The Veterans Administration definitions do not embrace the concept of long term, chronic care and effectively relegate patients in that category to nursing home level. This same limitation applied to the PSRO study which was referenced in the GAO report.

To state that the Veterans Administration "overpaid for care" is inaccurate and offensive. Patients treated at our hospital received the level of care appropriate to their medical condition and the cost was less than would have been incurred elsewhere, even in a Veterans Administration-operated nursing home. While some may not have met the Veterans Administration definition for hospital level, it is not at all certain that these patients could have been adequately managed in a nursing home setting without the ancillary services of a hospital.

One aspect of the report which was of particular interest was that of the nursing home program. We plan to pursue participation in this program so as to make this essential level of care available to the veterans of our State. We are grateful for the opportunity to participate in this project. The experience has been a profitable one for us and I am certain the results will benefit the veterans of Connecticut.

Sincerely,

Nicholas M. Motto

Colonel Nicholas M. Motto
Commandant

NMM:gkm

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Georgia War Veterans Home

A FACILITY OF
THE VETERANS SERVICE BOARD
OF GEORGIA

Milledgeville, Georgia 31062

OPERATED BY
THE DEPARTMENT OF
HUMAN RESOURCES

7 September 1981

Mr. Gregory J. Ahart
Director
United States Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Reference is made to your letter of August 14, 1981 concerning a draft report to Senator Alan Cranston. Because the letter was not received until 28 August 1981, Mr. Chuck Heese granted an extension of the deadline for reply to 13 September 1981.

The following comments pertaining to the draft report are submitted for consideration prior to preparation of the final report:

Paragraph 3, page 4. The VA does exercise considerable direct control over admissions to the Home. Presently, war veterans are not admitted until they are approved for VA reimbursement by the VAMC, Dublin.

Paragraph 3, page 8. We do not feel that our admission policies create a potential for overpayments. Our admission policies are as follows:

Application for Admission:

Application for admission must be submitted to the Home for determination of administrative and medical eligibility. Final approval for admission rests with the Veterans Administration. Application, including completed VA Form 10-10 "Application for Medical Benefits" and VA Form 10-10m "Medical Certificate" should be sent to the Director, Georgia War Veterans Home, Milledgeville, Georgia, 31062.

Administrative Eligibility Criteria:

. Must be a legal resident of Georgia and have maintained such residency for a minimum of one year.

. Served on active duty in the Armed Forces of the United States or on active duty in a reserve component of the Armed Forces of the United States, including the National Guard, during wartime or during the period beginning 31 January 1955 and ending 7 May 1975.

- Must have been discharged from service under other than dishonorable condition.
- Shall not be under a detainer from any court of law or law enforcement agency.
- Must not have criminal or civil charges pending.

Domiciliary Medical Eligibility Criteria:

Must have a disability, disease, defect or injury producing disablement of such degree and probable persistency as will incapacitate the veteran from earning a living for a prospective period, but not in need of hospitalization or nursing care services and be able to perform all of the following:

- Perform without undue assistance such activities of daily living as brushing teeth, bathing, shaving, combing hair.
- Dress self with a minimum of assistance.
- Proceed to and from the dining hall without undue aid.
- Feed self.
- Secure medical attention on an ambulatory basis or by use of self-propelled wheelchair.
- Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
- Participate in the treatment, rehabilitation and restorative activities prescribed.
- Make rational and competent decisions as to desire to remain or leave the Home.

A veteran is not eligible for admission to the Domiciliary if he has a medical or phychological disorder which is beyond the capacity of the Domiciliary to treat, improve or control.

Skilled Nursing Medical Eligibility Criteria:

Must not be acutely ill and not in need of hospital or domiciliary care, but require skilled nursing care and related medical services prescribed by and under the general direction of persons duly licensed to provide such care, must be approved for skilled care by the Veterans Administration, and shall require one or more of the following levels of care:

- Performance of any direct services that the physician judges can be provided safely only by licensed nursing care personnel or by non licensed personnel, such as the care of a tracheostomy requiring frequent suctioning.

- Continuous care by nursing personnel at the level of a licensed practical nurse or higher, such as the care of a terminally ill patient.

- Observation by a registered professional nurse or a licensed practical nurse at least once daily, and assessment of the total needs of the patient by such personnel, such as administration of treatments requiring observation and evaluation, warm soaks, heating pads.

- Administration and/or control of medications by licensed nursing care personnel, such as administration of routine medicines and intramuscular injections.

- A treatment plan including planning and administration of multiple services prescribed by a physician, such as care of totally bed-ridden patient.

- Continuing medical and nursing care of sufficient degree to necessitate the maintenance of a continuing clinical record, such as the care of colostomy and ileostomy in post-operative and debilitated patients and the care of chronically ill who will probably not improve dramatically.

Paragraph 2, page 16. No Georgia war veteran is assigned to our Skilled Nursing Units until, 1) Application has been approved by a Screening Committee consisting of physicians, registered nurses, social workers, and psychologists, 2) Application is approved by the VA, 3) Applicant completes a medical examination by the admitting physician. Applicants who do not meet medical entry criteria at any step of the processing are denied admission to skilled nursing.

Paragraph 2, page 21. It seems to us that the admission policies cited above do not create a "high potential" for overpayments.

Paragraph 2, page 22. Unless the VA has placement criteria we are not aware of, our admission policies do not appear to be contradictory or at variance with those of the VA. There is no intent to be inconsistent (refer to admission policies cited above).

Paragraph 3, page 22. Our physicians, assisted by other professional staff, determine levels of care required by an applicant based upon the diagnosis supported by medical history and physical findings. We do not place a veteran in skilled nursing until the VA agrees with our placement recommendations and the admitting physician has conducted a physical examination to verify the medical reports. We agree that there is "a grey area" between a category 4 skilled nursing and a domiciliary patient; however, we believe that our policies and system for determining placement are medically sound.

Paragraph 2, page 43. We view Federal funding above the $12.10 for skilled nursing and $6.35 for domiciliary care per resident per day as a Federal matter; however, increasing such funding is long overdue.

Likewise, whether the Georgia War veteran is charged for services rendered is a matter for the sovereign State of Georgia to determine through its Legislative and Executive branches of government.

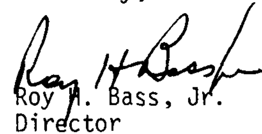
Paragraph 1, page 59. We do not participate in Part A or Part B Medicare because of existing State Legislation rather than "HHS red tape".

Paragraph 4, page 60. A decision to seek additional revenues to help offset increasing State home operating costs rests with the State Legislature and Governor. This matter has been considered at State level in the past and rejected. It is reasonable to assume that Georgia State policy is to help, aid, and assist the war veterans who served their country honorably in time of dire need.

Appendix II. We believe that per diem costs per patient per day of $47.69 for domiciliary and $61.47 for skilled nursing residents is considerably lower than shown. The bookeeping system used by Central State Hospital for determining costs may support these figures; however, their system for tracking indirect costs does not reflect true costs and can only be considered as approximate at best.

Please do not hesitate to call or write if additional information is needed.

Sincerely,



Roy H. Bass, Jr.
Director

RHBJr/ct
cc: Mr. Wheeler
Mr. Chapman

MISSOURI
VETERANS' HOME

HARVEY L. YOCUM
Administrator

ST. JAMES, MISSOURI 65559
TELEPHONE (314) 265-3271

DONALD L. POSKIN
Asst. Administrator

August 24, 1981

Mr. Gregory J. Ahart, Director
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

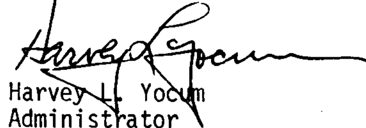
We have received and reviewed the draft report of your VA state home program study.

We have one major disagreement. On page 51, under the paragraph headed "Veterans could contribute more toward cost of care", is found the statement, "......, none of the homes we visited effectively used the pension and aid and attendance funds to defray the cost of care." We contend that Missouri has effectively used and is effectively using the pension and aid and attendance funds to defray the cost of care. As supporting evidence, I refer you to the table at the top of page 48 which shows Missouri paid only 9% of the state home cost compared to the other homes' percentages ranging from 49 to 85.

The table at the top of page 56 gives a false picture in that it fails to show that the $320 collected from the veteran in Missouri, when added to the VA per diem, represented the <u>total</u> cost of care provided. Please note that Missouri law mandates that charges be based on the costs for the "last full fiscal year".

We shall appreciate having these items clarified in your final report.

Very truly yours,



Harvey L. Yocum
Administrator

lmf

cc: Chuck Heese
Rita Frampton

The Commonwealth of Massachusetts
Soldiers' Home in Holyoke 01040

JAMES K. KELLY
SUPERINTENDENT

September 3, 1981

Mr. Gregory J. Ahart, Director
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

We have reviewed your draft on State Veterans' Homes and have the following comments:

Level of Care: We were not one of the homes with this problem. We have 27 hospital beds, of which only 11 are filled.

Other Sources of Revenue: We bill Medicare and all other 3d parties. We have analyzed four different systems of charges, none of which generates any significant amount of revenue. All four systems would be difficult to initiate and, of course, would require additional personnel to administer. This is especially difficult today when we are faced with a reduction in force from 345 authorized positions to 302!

Quality of Care: We are reviewed and inspected by the JCAH, the Department of Public Health and the V.A. on a continuous basis. We have always received accreditation from the JCAH.

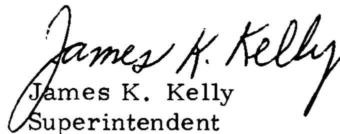
You have indicated in your draft the demand for nursing home beds. The increase for these beds will be 50,000 between 1980 and 1990. No one is more aware of this problem than we are. Today we have a waiting list in excess of 100 veterans who need a nursing home bed.

The State can no longer pay such a large share of our operating costs. For example, in FY 1980 the state paid 70% of this institution's operating costs. We generated revenues equal to 30% from V.A., Aid & Attendance, Medicare, Blue Cross & Medex and Commercial Insurers which we turn back to the General Fund.

What the GAO failed to recognize in this report were things like President Reagan's budget cut, Massachusetts's Proposition $2\frac{1}{2}$, and Collective Bargaining problems at the institutions. The individual agencies are now being forced to bear the brunt of these problems; for example, this agency is to absorb $300,000 in collective bargaining costs in FY 1982, as well as give up $75,000 in equipment requests. This means a possible layoff of 27 people and the possible closing of a nursing care unit. This seems ridiculous at a time when these beds are in such demand.

What must be done is for the V.A., the NASVH, and the individual states to take a hard look at a reimbursement policy that is fair and equitable to not only these organizations but to the Veteran also.

Sincerely yours,



James K. Kelly
Superintendent

JKK:RP:SK

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