United States Government Accountability Office

Report to Congressional Addressees

November 2022

VA NURSING HOME CARE

Opportunities Exist to Enhance Oversight of State Veterans Homes

Accessible Version

GAO-23-105167

GAO Highlights

Highlights of GAO-23-105167, a report to congressional addressees

November 2022

VA NURSING HOME CARE

Opportunities Exist to Enhance Oversight of State Veterans Homes

Why GAO Did This Study

Many aging veterans rely on nursing home care to meet their daily needs. In fiscal year 2021, VA paid about $1.5 billion for veteran nursing home care provided in state veterans homes.

GAO was asked to provide information on VA's oversight of state veterans homes, and the joint explanatory statement accompanying the Consolidated Appropriations Act, 2021, contained a provision for GAO to review the relationship between VA and these homes. This report (1) describes the oversight of state veterans homes to ensure compliance with quality standards; (2) examines available data about deficiencies cited during inspections; and (3) examines how VA could enhance its oversight of state veterans homes.

GAO conducted a nationwide survey to collect information on the 153 state veterans homes providing nursing home care. GAO analyzed data from VA's annual inspections for 2019 and 2021. (Data were not available for 2020 because inspections were suspended due to the COVID-19 pandemic.) GAO also reviewed relevant statutes, regulations, and VA documents, and interviewed federal and state officials and organizations involved with veteran care.

What GAO Recommends

GAO is making four recommendations to VA, including that it identify additional enforcement tools to ensure state veterans home compliance with quality standards, and seek legislative authority for them, as appropriate. VA agreed with the recommendations.

View GAO-23-105167. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) is the only federal entity that oversees all 153 state veterans homes, which provide nursing home care to roughly 14,500 veterans. While these homes are owned and operated by states, VA helps pay for care for eligible veterans and is required to ensure the homes meet VA's quality standards. To do this, VA conducts regular inspections, and homes that do not meet standards can be cited for deficiencies. The Centers for Medicare & Medicaid Services (CMS) also conducts inspections in the nearly 76 percent of state veterans homes that receive Medicare or Medicaid payments and, like VA, can cite deficiencies. In response to GAO's national survey of state agencies that operate state veterans homes, 43 states reported also inspecting homes for compliance with state-specific regulations or on a for-cause basis.

GAO's analysis of VA's available annual inspection data for 2019 and 2021 found increases in both the number and the severity of deficiencies cited. For example, the total number of deficiencies increased from 424 in 2019 to 766 in 2021. A majority of the increase was in the quality of care and infection control categories, which cover accidents and staff hand hygiene. Additionally, GAO found that, for those homes with annual inspection data available in both 2019 and 2021, many were cited for deficiencies in the same standard.

GAO found that VA could enhance oversight by, among other things, an expansion of the tools it has to bring these homes into compliance with quality standards. According to VA officials, compared to CMS, VA lacks a range of enforcement actions to use to bring state veterans homes into compliance (see figure). Specifically, VA's only enforcement action is to withhold payment to compel homes to come into compliance. VA considers this action too severe for most situations. VA officials said they are considering seeking legislative authority to take additional enforcement actions to ensure compliance with quality standards. Having such tools would strengthen VA's ability to better ensure that veterans receive quality care in these homes.

Available Enforcement Actions for Department of Veterans Affairs and Centers for Medicare & Medicaid Services

VA ENFORCEMENT ACTIONS	SELECTED CMS ENFORCEMENT ACTIONS
• Withhold payment for daily veteran care	• Civil monetary penalties (fines for each day or instance of noncompliance) • Denial of payment for all newly admitted eligible residents • State monitoring (on-site monitor to achieve and maintain compliance) • Termination from the Medicare and Medicaid programs

Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-23-105167

Text of Available Enforcement Actions for Department of Veterans Affairs and Centers for Medicare & Medicaid Services

- Enforcement Actions:
    - Withhold payment for daily veteran care

- Selected CMS enforcement actions:
  - Civil monetary penalties (fines for each day or instance of noncompliance)
  - Denial of payment for all newly admitted eligible residents
  - State monitoring (on-site monitor to achieve and maintain compliance)
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Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-23-105167

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Abbreviations

COVID-19	Coronavirus Disease 2019
CMS	Centers for Medicare & Medicaid Services
GEC	Office of Geriatrics and Extended Care
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VISN	Veterans Integrated Service Network

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

November 14, 2022

Congressional Addressees

Like many older Americans, aging veterans may rely on nursing home care to meet their daily needs. The Department of Veterans Affairs (VA) provides or pays for nursing home care for eligible veterans. In fiscal year 2021, this care cost almost $7.3 billion for approximately 33,000 veterans whose health care needs were extensive enough to require skilled nursing and personal care in an institutional setting. Almost half of these veteransNoabout 14,500Noreceived this nursing home care in state owned and operated facilities known as state veterans homes. In fiscal year 2021, VA provided funding for nursing home care for veterans in 153 state veterans homes across the country at a cost of about $1.5 billion.[1]

To receive VA payments, state veterans homes must meet VA quality standards related to quality of care, quality of life, infection control, and resident rights, among other areas. Homes that fail to meet the standards can be cited for deficiencies by VA. Some of these homes also receive Medicare or Medicaid payments from the Centers for Medicare & Medicaid Services (CMS). These homes must also meet CMS quality standards and can be cited for deficiencies by CMS.

In recent years, we have examined the quality of care at state veterans homes and VA's oversight of this care. For example, in November 2020, we reported that VA had paused inspections during the COVID-19 pandemic.[2] VA resumed inspections in January 2021. VA's overall efforts to provide timely, cost-effective, and quality care to veterans have been a focus of our work for many years. In 2015, VA health care was added to

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[1]As of January 2022, 160 state veterans homes were officially recognized by VA. Of those, 153 provide nursing home care. The remaining 7 are domiciliaries only.

[2]See GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, GAO-21-191 (Washington, D.C.: Nov. 30, 2020).

our High Risk List, due to challenges we identified in VA's provision of services.[3]

We were asked to provide information on VA's oversight of state veterans homes, and the joint explanatory statement accompanying the Consolidated Appropriations Act, 2021, contained a provision for us to review the relationship between VA and these homes.[4] This report

1. describes the oversight being conducted to ensure state veterans homes' compliance with nursing home quality standards;
2. examines what available data show about deficiencies cited during recent state veterans home inspections; and
3. examines how VA could enhance its oversight of state veterans home to ensure compliance with quality standards.

To describe the oversight of state veterans homes to ensure compliance with nursing home quality standards, we reviewed federal documents, conducted a national survey, and interviewed officials from VA and other organizations. We reviewed VA and CMS documents about state veterans home inspection policies and processes.[5] We also reviewed prior GAO work about how VA conducts inspections of these homes. Additionally, we surveyed officials from the state agencies that operate state veterans homes in each of the 50 states and Puerto Rico.[6] We conducted the survey from March 16 through April 14, 2022; we received 51 responses for a response rate of 100 percent. We reviewed the survey

[3]GAO's high-risk program identifies government operations with vulnerabilities to fraud, waste, abuse, and mismanagement, or in need of transformation to address economy, efficiency, or effectiveness challenges. See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021).

[4]See 166. Cong. Rec. H8742 (daily ed. Dec, 21, 2020) (statement of Rep. Lowey regarding Consolidated Appropriations Act, 2021, Pub. L. No. 116-260).

[5]Assessing VA and CMS processes for duplicative goals and activities was outside the scope of our review. While GAO annually identifies federal programs and agencies with duplicative goals and activities across government, we recognize that there could be instances where some degree of program fragmentation, overlap, or duplication may be warranted because of the nature or magnitude of the federal effort. See GAO, *Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Billions of Dollars in Financial Benefits: Annual Report* GAO-22-105301 (Washington, D.C.: May 11, 2022).

[6]Washington, D.C., does not have any state veterans homes. To help develop the survey, we pretested the survey instrument with state officials from the respondent population from three different states.

responses for any internal inconsistencies, and for discrepancies from VA documentation for certain information collected in the survey. We conducted follow-up with states to resolve discrepancies as needed. Additionally, we interviewed officials from VA, the National Association of State Veterans Homes, and the National Association of State Directors of Veterans Affairs.

To examine what available data show about the deficiencies cited at state veterans homes, we reviewed data from VA's annual inspections of state veterans homes that were completed in 2019 or 2021. While VA refers to these annual inspections as "surveys," for the purposes of our reporting, we refer to them as inspections. We discuss relevant information from these inspections, such as the number and types of deficiencies cited, severity of these deficiencies as classified by VA, and state veterans home plans to correct deficiencies cited in each inspection. We did not include 2020 in our analysis because, as mentioned, VA suspended all annual inspections in March 2020 in response to the COVID-19 pandemic; inspections resumed in January 2021. We determined VA's annual inspections data were reliable for our reporting objective after reviewing VA's directive for inspecting state veterans homes and interviewing knowledgeable VA officials to better understand the data. We identified weaknesses in the data, as discussed in this report.

In addition to VA data, we reviewed the publicly available CMS Five-Star Quality Rating data for the state veterans homes that also receive CMS oversight.[7] We reviewed CMS's technical manual for its rating data and compared the performance of these state veterans homes against other types of nursing homes in their respective state. We determined the CMS data were sufficiently reliable for the purpose of our objective.

To examine how VA can enhance its state veterans home oversight to ensure compliance with quality standards, we reviewed VA documents on the oversight process for state veterans homes. These documents included VA directives on requirements for annual inspections and on the payments to state veterans homes for care provided to veterans; contracts with agencies hired by VA to inspect the homes; presentations outlining changes to VA's oversight structure; and an enterprise data

[7]We provided CMS officials with an opportunity to review key facts presented in this report and incorporated their relevant technical comments.

strategy, among other things. We also reviewed applicable statutes and regulations pertaining to VA's oversight authorities.

We interviewed knowledgeable VA officials, as well as representatives from the National Association of State Veterans Homes and National Association of State Directors of Veterans Affairs to understand state veterans home and state government perspectives.[8] Further, we interviewed officials from five state veterans homes to better understand VA's oversight in individual homes. We selected the five homes to capture variation across characteristics including management type, oversight entity, bed size, and geographic location. The findings from the five selected homes in our sample are not generalizable to all state veterans homes. We assessed whether VA's oversight efforts were consistent with its oversight policies and planning documents and with relevant federal internal control standards related to information and communication.[9]

We conducted this performance audit from April 2021 to November 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA provides or pays for nursing home care in three nursing home settings: VA-owned and -operated community living centers, publicly or privately owned community nursing homes, and state-owned and -operated state veterans homes. In general, the three settings provide similar nursing home care, in which veterans receive skilled nursing care,

[8]We also reached out to representatives from six veteran service organizations. We received responses from three of these organizations.

[9]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014). Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity.

recreational activities, and other services.[10] While the cost of care varies across the three settings, in fiscal year 2021, the average daily cost for veterans receiving VA- supported nursing home services was lowest in state veterans homes, where the largest share of veterans get their care.[11]

Support of State Veterans Homes

VA supports state veterans homes by providing per diem payments for each day that each eligible veteran is receiving care and has an overnight stay, with certain exceptions.[12] VA also provides grants to construct, acquire, remodel, or modify state veterans homes, and payments to states for the hiring and retention of nurses.[13] State veterans homes are owned and operated by states. Federal statute prohibits VA from having authority over the management of or control of any state home.[14]

[10]Some of the nursing homes may provide care to veterans on a short-term basis, such as rehabilitation after a hospitalization for a period of 90 days or less (“short stay”), or on a long-term basis, which is a period of 91 days or more (“long stay”). Further, officials previously told GAO that some of these homes may also provide certain special needs care for a limited number of residents, such as dementia or rehabilitative care, which may require additional specialized equipment or trained staff.

[11]The average daily costs per veteran per day at state veterans homes was $285 in fiscal year 2021, according to VA’s fiscal year 2023 budget submission. In that same year, the average daily cost for the 6,684 veterans in VA’s community living centers was $1,850.39, and for the 9,928 veterans in community nursing homes, the average daily cost was $347.12. These numbers do not include care veterans received at other types of state veterans homes, such as those providing only domiciliary care.

[12]See 38 U.S.C. §§ 1741, 1745. In certain circumstances, VA also pays per diem when there is no overnight stay (i.e., the veteran is temporarily absent from the facility) if the facility has a 90 percent or greater occupancy rate.

[13]See 38 U.S.C. §§ 8131-8138 and § 1744.

[14]38 U.S.C. § 1742(b).

Depending on the veteran, VA pays the full or partial cost of state veterans home care.[15] States have different methods of funding the remaining balance, including private out-of-pocket payments from the veteran or state general funds. States might also obtain payment from CMS for services furnished to eligible individuals in state veterans homes certified to participate in Medicare or Medicaid.

Oversight of Quality of Care in State Veterans Homes

Federal law and VA policy prevent VA from making payments to state veterans homes until it determines that they meet applicable quality of care and other standards.[16] Within VA, the Office of Geriatrics and Extended Care (GEC) is responsible for overseeing the quality of care provided to veterans at state veterans homes. Each home is affiliated with a VA medical center (VAMC). The VAMC of jurisdictionNousually the VAMC located closest to the homeNois responsible for helping veterans make decisions about nursing home care, responding to inquiries from state veterans home management, referring management to the appropriate VA office for assistance, and serving as an educational resource for state veterans home employees, among other things.[17] Each VAMC resides within a Veterans Integrated Services Network (VISN), and

[15]According to VA policy, its payments are equal to the lesser of the annual basic per diem rateNodetermined annually on a fiscal year basisNoor one-half of the daily cost of nursing home care provided to eligible veterans in the state veterans home. VA is required by law to provide the full cost of nursing home care for veterans who need nursing home care for a service-connected disabilityNowhich is an injury or disease that was incurred or aggravated while on active dutyNoand for veterans with service-connected disabilities rated at 70 percent or more. Unless reauthorized by Congress, this statutory requirement will terminate on September 30, 2022. See 38 U.S.C. § 1710A(a). For these veterans, VA makes prevailing rate per diem payments. See 38 C.F.R. § 51.41 (2021).

[16]38 U,S.C. § 1742(a); Department of Veterans Affairs, Veterans Health Administration (VHA), *Survey Requirements for State Veterans Homes,* VHA Directive 1145.01 (Washington, D.C.: Feb. 18, 2021).

[17]Before January 2022, VAMCs of jurisdiction for each state veterans home managed most of VA's oversight of the homes. In January 2022, GEC officials said they began to centralize many of the inspection oversight tasks previously conducted by VAMC representatives.

GEC works with liaisons within each VISN to address state veterans home quality issues, as needed.[18]

VA conducts inspections that determine the extent to which state veterans homes meet relevant nursing home quality of care standards.[19] VA contracts with a third party to conduct these inspections and is responsible for monitoring the contractor's performance. The contract stipulates that such monitoring includes directly observing 10 percent of the inspections, sampling 50 percent of the contractor's inspection reports and reviewing them for any needed corrections, and validating 90 percent of the reports for timely submission.

The first inspection a home receives after it applies to receive VA's per diem payments is to recognize the home as a state veterans home. VA reviews policies, procedures, staffing patterns, and all other requirements appropriate to the facility's level of care, and issues a pass or fail decision for the facility. For those that pass, subsequent inspections are generally unannounced and typically occur annually or in response to a specific incident or complaint. Subsequent inspections are intended to ensure the home continues to meet applicable standards. Those that meet all standards are certified by VA and continue to receive per-diem payments.

Any applicable standard that VA's inspectors find to be "not met" during an inspection triggers a deficiency citation to the state veterans home. Each deficiency is classified using a system that CMS developed for its investigations. VA rates each deficiency for its scopeNowhich indicates whether the deficiency is isolated to one patient, a pattern, or widespread; and its severityNowhich indicates whether the deficiency can cause harm or poses immediate jeopardy to resident health or safety. State veterans homes must submit a corrective action plan for each deficiency cited during a VA inspection; included in these plans are specific steps that must be taken to correct the deficiency. Homes with an accepted corrective action plan in place are provisionally certified and are eligible for per-diem payments.

[18]VA provides healthcare services through 18 geographically divided VISNs. Each VISN is responsible for coordination and oversight of all administrative and clinical activities within its specified geographic region.

[19]VA will inspect the home in accordance with 38 C.F.R. § 51.31 to determine whether the home and program of care meet the applicable requirements of 38 C.F.R. Part 51, Subpart C, and the applicable standards in Subparts D, E or F.

While VA is the only federal agency that oversees all state veterans homes, CMS also oversees many of them due to their participation in Medicare or Medicaid as part of CMS' oversight of over 15,000 certified nursing homes nationwide.[20] CMS enters into agreements with state agencies to inspect these homes, as it does for all nursing homes it inspects.

Prior GAO Work on State Veterans Homes

We have previously reported on VA's oversight in state veterans homes and identified opportunities for improved oversight. For example, in 2019 we found that VA did not require that all failures to meet standards be documented as cited deficiencies, unlike CMS; nor did VA monitor the contractor's performance to ensure that contractor staff effectively determine whether state veterans homes are meeting required standards.[21] VA has since addressed these issues. We have also found that, even though VA is the only source of information about the quality of state veterans homes, it does not make such information publicly available. We recommended that VA do so. VA concurred in principle but has not fully addressed this recommendation as of August 2022.[22]

It is particularly important that VA ensure veterans receive quality care because, as we have previously reported, veterans' use of long-term care services has increased in recent years and VA projects the trend to continue.[23] Furthermore, ensuring the quality of care provided at state veterans homes has become even more critical since the emergence of COVID-19. Nursing home residents are often in frail health and living in close proximity to one anotherNoand therefore at higher risk of being infected with and dying from COVID-19. In 2021, VA addressed a previous recommendation we made to include timely data on COVID-19 cases and deaths among staff and residents at state veterans homes on

[20]Some state veterans homes may also receive inspections from the Joint Commission, a nonprofit organization that provides voluntary health care accreditation for hospitals.

[21]See GAO, *VA Nursing Home Care: VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website,* GAO-19-428 (Washington, D.C.: July 3, 2019).

[22]See GAO-19-428.

[23]See GAO, *VA Health Care: Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting Demand,* GAO-20-284 (Washington, D.C.: Feb. 19, 2020).

its website, which is useful for overseeing whether the homes effectively took steps to prevent and mitigate the spread of COVID-19.[24]

VA, CMS, and Most States Conduct Inspections to Oversee State Veterans Homes' Compliance with Relevant Quality Standards

VA conducts annual inspections of all state veterans homes, and CMS conducts its own inspections in nearly 76 percent of these homes. In response to our national survey of officials from state agencies that operate state veterans homes that provide nursing home care, 43 states reported conducting their own inspections in addition to the oversight conducted by VA and CMS.

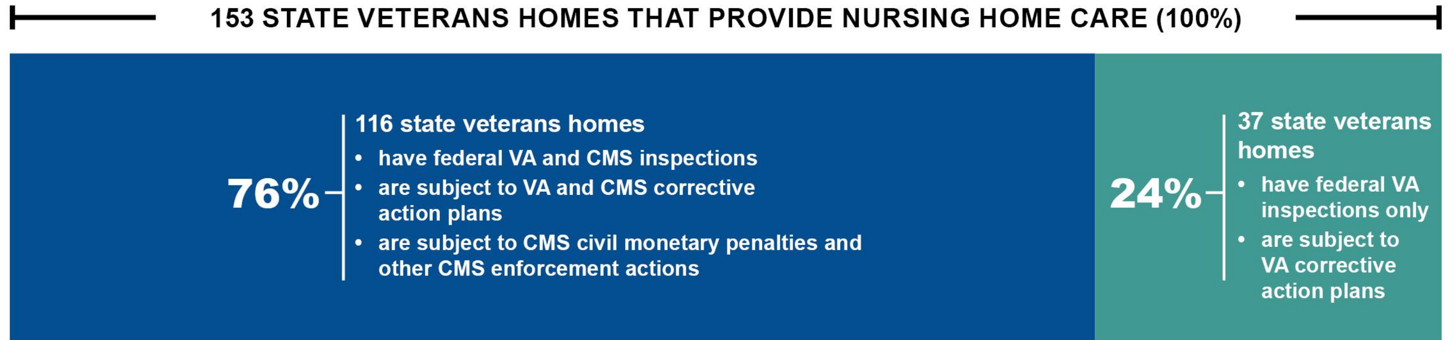
VA and CMS Inspections

To help ensure state veterans homes are meeting VA's quality standards, the department is responsible for conducting regular inspections of all of these homes, the only federal entity to do so.[25] As shown in figure 1, nearly 76 percent of state veterans homes that provide nursing home care (116 of 153 as of January 2022) are also inspected by CMS to ensure they meet the federal quality standards required to receive Medicare or Medicaid payments.

[24]See GAO-21-191.

[25]While state veterans homes are owned and operated by the states, federal law stipulates that VA may inspect any state veterans home at such times as the Secretary deems necessary. 38 U.S.C. § 1742(a).

Figure 1: Federal Oversight of State Veterans Homes by the Department of Veterans Affairs (VA) and the Centers for Medicare and Medicaid Services (CMS), as of January 2022



Source: GAO analysis of data from Department of Veterans Affairs (VA) and Centers for Medicare & Medicaid Services (CMS). | GAO-23-105167

Text of Figure 1: Federal Oversight of State Veterans Homes by the Department of Veterans Affairs (VA) and the Centers for Medicare and Medicaid Services (CMS), as of January 2022

153 State Veterans homes that provide nursing home care

- 76%: 116 state veterans homes
  - have federal VA and CMS inspections
  - are subject to VA and CMS corrective
  - action plans
  - are subject to CMS civil monetary penalties and other CMS enforcement actions
- 24%: 37 state veterans homes
  - have federal VA inspections only
  - are subject to
  - VA corrective action plans

Source: GAO analysis of data from Department of Veterans Affairs (VA) and Centers for Medicare & Medicaid Services (CMS). | GAO-23-105167

Note: CMS has the ability to take a variety of enforcement actions, including imposing civil monetary penalties of varying amounts.

VA documentation shows that VA's inspection program is modeled upon CMS inspection methods. VA policy calls for inspections of state veterans homes on a regular schedule, approximately yearly, to assess

compliance with 189 standards across 16 categories.[26] CMS policy calls for CMS to inspect nursing homes, including state veterans homes, every 15 months or less. CMS assesses compliance with standards that are grouped into 22 categories.[27] Both agencies examine the extent to which the homes are meeting applicable quality of care standards, among other issues.[28] Additionally, both VA and CMS conduct for-cause inspectionsNowhich are typically unannouncedNothat may arise from complaints or facility reported incidents.

During inspections, if VA's contractor identifies any standard that is "not met," it cites the home for a deficiency. The deficiency is rated for its scope and severity.[29] The contractor is required to provide a written description of the deficiency and its rating to VA. Then VA is to send a signed letter of the inspection results, including reasons for any deficiency, to the home's management within 20 business days from the last day of the inspection.

Both VA and CMS require state veterans homes to develop a corrective action plan for each deficiency in a routine or for-cause inspection.[30] VA requires the plans to state specific interventions with target dates for remediation; identify trends and patterns; consider core causes; and include a plan to monitor effectiveness over time. According to VA policy, VA will review the plan and either approve it or find it not acceptable because it does not address the deficiency or cannot be completed in a reasonable time period. If not approved, the home must submit a revised plan. CMS similarly requires the home to detail its planned corrective actions and the anticipated date of correction. Depending on the scope

[26]VA inspections check for 16 categories of standardsNo15 in 38 C.F.R. Part 51, Subpart D, and other standards in Subpart C of this part, which VA has previously counted under a single category.

[27]See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2021).

[28]CMS and VA assess compliance with similar categories of standards, such as quality of care and quality of life, while only VA inspections include a fiscal component.

[29]VA uses a matrix adapted from CMS for deficiency ratings. "Scope" generally refers to whether the deficiency is isolated to one patient or widespread, and "severity" generally refers to whether the deficiency can cause injury, harm, impairment, or death.

[30]The CMS form is named Statement of Deficiencies and Plan of Correction (Form CMS-2567), but we use the term "corrective action plan."

and severity of the deficiency, the CMS state agency may re-visit the home to ensure it implemented the plan and corrected the deficiency.

CMS has the authority to impose monetary penalties on state veterans homes with deficiencies, while VA officials noted they cannot.[31] CMS penalties vary based on factors including whether a deficiency is classified as causing immediate jeopardy to residents' health or safety. For example, in 2022, CMS policy requires civil monetary penalties up to $23,989 per day for deficiencies where there is immediate jeopardy, and up to $7,195 per day when there is no immediate jeopardy. VA officials said the department can, upon approval of the VA Secretary, withhold its per diem payments to state veterans homes if the home has a deficiency that VA determines is egregious, makes no attempt to fix it, and has a history of well-documented non-compliance.

See appendix I for additional detail on federal state veterans home oversight by VA and CMS.

State Oversight Activities

Through our national survey of officials from state agencies, 43 states reported conducting some kind of oversight on their state veterans homes separate from federal oversight.[32] States own and operate state veterans homes and, as a result, states may conduct their own oversight activities of the homes. (See appendix II for the survey responses with information reported about each state veterans home, and appendix III for the survey responses about state-specific oversight policies and a summary of state veterans homes in each state.)

States that reported conducting some kind of oversight reported doing so through either routine inspections based on state-specific nursing home quality regulations, for-cause inspections, or both.

[31]See 42 U.S.C. §§ 1395i-3(h)(2)(B)(ii), 1396r(h)(3)(C)(ii); 42 C.F.R. § 488.438 (2021). See 45 C.F.R. § 102.3 (2021) for annually adjusted civil monetary penalty amounts.

[32]We deployed the survey in all 50 states and Puerto Rico (Washington, D.C., does not have any state veterans homes), but Wyoming is excluded from this analysis because it reported not having any state veterans homes that provide nursing home care. The survey also asked for background information about all state veterans homes.

Of the 43 states that reported conducting their own oversight,

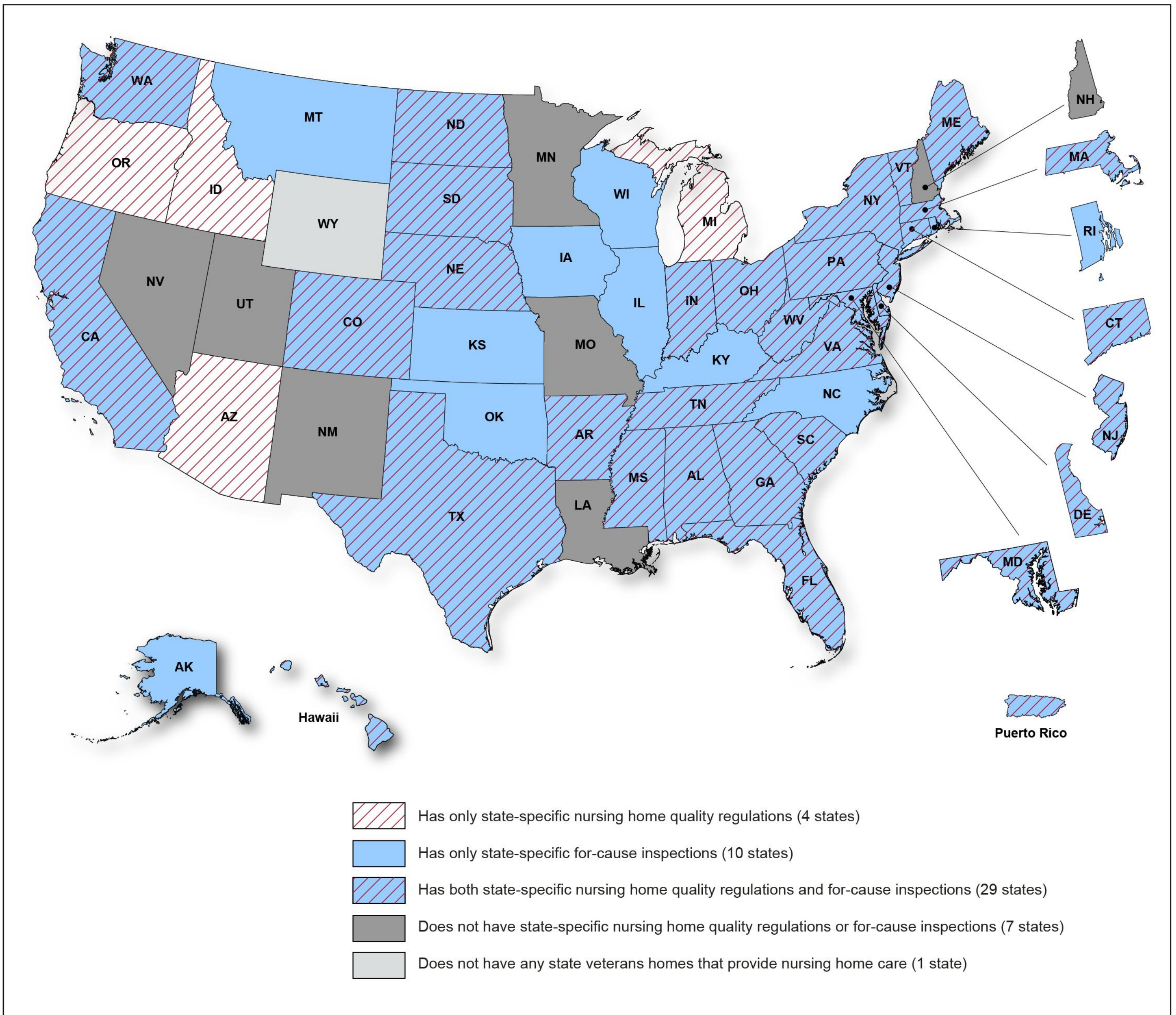
- 33 reported having state-specific nursing home quality regulations;
- 39 reported conducting for-cause inspections that are separate from federal (i.e., VA or CMS) for-cause inspections; and
- 29 reported both types of oversight.[33]

In contrast, 7 states reported they do not have either state-specific nursing home quality regulations or for-cause inspections. Like all states, these states' homes are subject to VA inspections and some also receive CMS inspections. Among the 25 state veterans homes that provide nursing home care in these states, 8 of themNothose in New Hampshire and MissouriNoare not inspected by CMS because they are not Medicare- or Medicaid-certified, and only receive oversight from VA.

See figure 2 for a map that indicates which states reported having state-specific nursing home quality regulations, for-cause inspection, both, or neither.

[33]Additionally, all of the states except California and Massachusetts reported that they require state veterans home administrators to hold a nursing home administrator license.

Figure 2: Map of Certain State-Specific Oversight Activities for State Veterans Homes



Source: GAO; Map Resources (map). | GAO-23-105167

Note: Information for each state in figure 2 is current as of the date of each state's survey completion, which varied by state from March to April 2022.

The states that reported having state-specific nursing home quality regulations varied in when and how they assessed compliance with these

regulations. These states reported assessing compliance with the regulations in either a routine state inspection (13 states); during a routine CMS inspection, because the homes are also CMS-certified (15 states); or in both a routine state inspection and during routine CMS inspections (5 states). According to the survey responses, there are a number of different state agencies that conduct the separate state inspections, including departments and offices of health, long-term care, health care administration, community health, healthcare assurance, and human services.

Of the 43 states that reported assessing compliance with state-specific nursing home quality regulations or conducting their own for-cause inspections, 41 reported requiring state veterans homes to use a corrective action plan, separate from any federal plan to bring deficiencies into compliance. Additionally, 37 states reported they have the option to take one or more enforcement actions if a home does not meet state standards. Survey respondents reported various types of enforcement actions their states can take, including issuing monetary penalties or fines (30 states), closing the home (28 states), and suspending admissions to the home (27 states).[34] See appendix III for a state-by-state list of available enforcement actions as reported by state officials in the survey responses.

VA Data Show an Increase in Deficiencies Cited on State Veteran Home Inspections

Our analysis of VA's annual inspection data for 2019 and 2021 found increases in both the number of deficiencies and the number of deficiencies that were classified as causing actual harm, including

[34]Other types of enforcement actions that states reported they can take include withholding state payments or funds (21 states), having a different state agency temporarily take over management of the home (16 states), revoking the home's license (4 states), and imposing fines or imprisonment for operating a facility without a license (1 state).

immediate jeopardy.[35] (As previously noted, we did not include 2020 in our analysis because VA halted annual inspections in March 2020 in response to the COVID-19 pandemic; inspections resumed in January 2021.) Specifically, we found that the number of deficiencies increased from 424 in 2019 to 766 in 2021.[36] Similarly, the average number of deficiencies cited per inspection increased from 2.8 in 2019 to 6.2 in 2021.[37] Further, 36 state veterans homes had no deficiencies in 2019; in 2021 all homes had at least one deficiency that caused no actual harm

[35]Data for 2019 is from 150 annual inspections of state veterans homes; data for 2021 is from 123 inspections. As a result, the number of deficiencies reported in 2021 is fewer than what would have been found had all the homes been inspected in that year, as they were in 2019. That means that comparisons in the number of deficiencies between 2019 and 2021 underestimate the magnitude of the difference where the reported numbers are higher for 2021. In addition, when the numbers of reported deficiencies are higher in 2019, the number of deficiencies in 2021 might actually have been higher had inspection results for the missing homes been included. Similarly, any percentages reported for 2021 are either higher or lower than what they would have been had the full population of homes been inspected.

There were fewer inspections in 2021 because 28 homes received an interim records review from VA’s GEC in January 2021 in lieu of an annual inspection. We did not include the results of these record reviews in our analysis due to the limited number of standards they reviewed. Specifically, interim records reviews checked compliance with 22 standards, while annual inspections in 2021 checked more than 180. VA officials told us they completed these reviews because these 28 homes were about to have their certification lapse. Homes must be certified every 600 calendar days in order to receive per diem payments.

[36]Our analysis of VA inspection data found that about 22 percent of the increase in overall deficiencies may be attributable to a change in how VA cited deficiencies in 2019 and 2021. Specifically, in 2019, VA allowed non-compliance that received a severity rating of causing no actual harm but with the potential for minimum harm to be cited as “recommendations” rather than deficiencies. In GAO-19-428, we recommended that VA require all non-compliance with standards be cited as deficiencies. VA has since implemented this recommendation.

[37]According to VA summary data the average number of deficiencies per survey ranged from 1.8 to 2.6 between 2015 and 2018.

but had the potential for more than minimal harm. VA officials identified several factors that may have contributed to the increase in deficiencies.[38] For example, social isolation of residents in response to COVID-19 may have contributed to more falls in 2021.

[38]VA officials told us differences in how inspections were conducted in 2019 and 2021 could have affected state veteran home performance on VA's inspections, but that potential effects are unknown. Specifically, prior to halting inspections in March 2020, all annual inspections were conducted in person by a contractor on behalf of VA; there was no option for virtual inspections. In response to the COVID-19 pandemic, VA awarded a new contract with an option for virtual inspections beginning in January 2021. VA officials told us they use several criteria when determining if an inspection should be done virtually or in-person, such as the prevalence of COVID-19 in the community and the availability of Wi-Fi at the nursing home. According to VA data, most annual inspections between January 2021 and March 2022 were completed virtually. Since then, VA has begun completing a majority of its inspections in-person. For example, between July and September 2022, VA completed 69 percent of its inspections in-person, and 31 percent virtually.

Severity and Scope of Deficiencies

Deficiencies are rated for severity (effect of noncompliance) and scope (number of residents, employees, or locations affected).

Severity

- **Immediate jeopardy**: caused, or is likely to cause, serious injury, harm, impairment, or death
- **Actual harm that is not immediate jeopardy**: results in actual harm that is not immediate jeopardy
- **No actual harm with potential for more than minimal harm:** results in the potential for no more than minimal physical, mental, or psychosocial harm, or in minimal discomfort, but has the potential to result in more than minimal harm that is not immediate jeopardy
- **No actual harm with potential for no more than minimal harm**: has the potential for causing no more than minor negative impact

Scope

- **Widespread**: pervasive through the facility or represented systemic failure that affected or had the potential to affect a large portion or all of the facility's residents
- **Pattern**: affected more than limited number of residents, or employees involved, or the situation occurred in several locations but the locations are not dispersed through the facility
- **Isolated**: affected one or a limited number of residents or a limited number of employees involved, or the situation occurred only occasionally or in a limited number of locations

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-23-105167

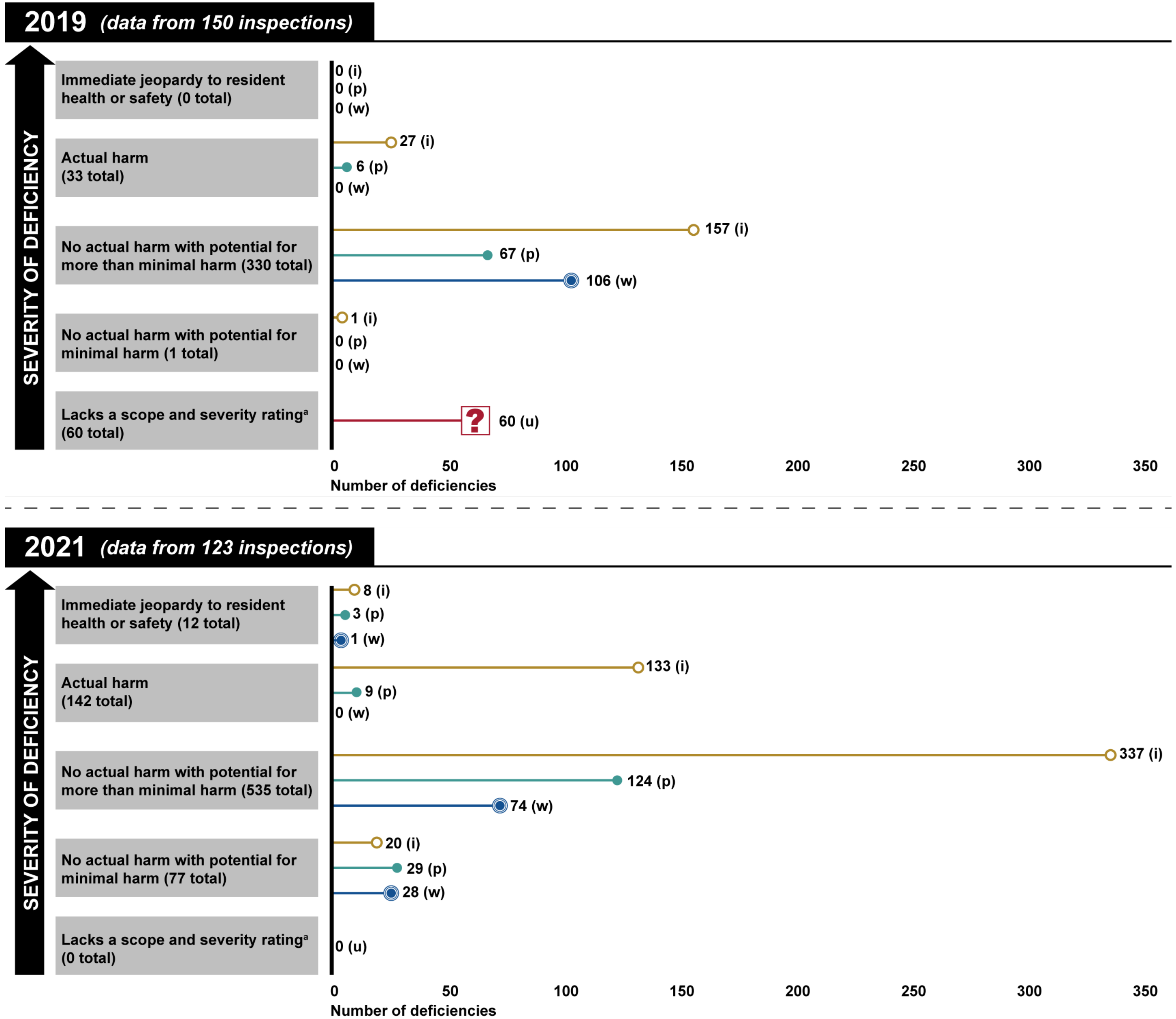
Our analysis found the most common scope and severity ratings for deficiencies in 2019 and 2021 were the lower level ratingsNoisolated in scope and no actual harm (see fig. 3). However, we found that deficiencies that caused actual harm or immediate jeopardyNothe most severe ratingsNoincreased as a share of total deficiencies from 8 percent in 2019 to 20 percent in 2021. Further, the percent of state veterans homes with at least one deficiency that caused actual harm increased

from 9 percent in 2019 to 63 percent in 2021.[39] About 79 percent of all deficiencies in 2021 with a severity rating of actual harm resulted from non-compliance with standards associated with preventing accidents; preventing and treating pressure sores (i.e., bedsores); and providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.[40]

[39]For example, a resident suffered fractured ribs after four falls over a 4-month period. The inspector found that the home's documentation did not address causal and contributing factors to the resident's falls, such as the condition of the environment and what the resident was attempting to do. The home was cited for a deficiency that caused actual harm because the home failed to ensure that residents received adequate supervision to prevent accidents and that the environment remained as free of accident hazards as possible.

[40]For example, a facility was cited for not providing the necessary care because it failed to adequately assess a resident's knee and shoulder pain. Specifically, the facility did not assess the type of pain, what aggravated and alleviated the pain, interventions that previously worked or did not work, and the resident's acceptable level of pain.

Figure 3: Count of Deficiencies in 2019 and 2021, by Deficiency Severity and Scope



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-23-105167

Data table for Figure 3: Count of Deficiencies in 2019 and 2021, by Deficiency Severity and Scope

2019 -- (data from 150 inspections)

	Category	Isolated	Pattern	Widespread
Severity of deficiency from highest to lowest	Immediate jeopardy to resident health or safety (0 total)	0	0	0
	Actual harm (33 total)	27	6	0
	No actual harm with potential for more than minimal harm (330 total)	157	67	106
	No actual harm with potential for minimal harm (1 total)	1	0	0
	Lacks a scope and severity rating[a] (60 total)	n/a	n/a	n/a

2021 -- (data from 123 inspections)

	Category	Isolated	Pattern	Widespread
Severity of deficiency from highest to lowest	Immediate jeopardy to resident health or safety (12 total)	8	3	1
	Actual harm (142 total)	133	9	0
	No actual harm with potential for more than minimal harm (535 total)	337	124	74
	No actual harm with potential for minimal harm (77 total)	20	29	28
	Lacks a scope and severity rating[a] (0 total)	n/a	n/a	n/a

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-23-105167

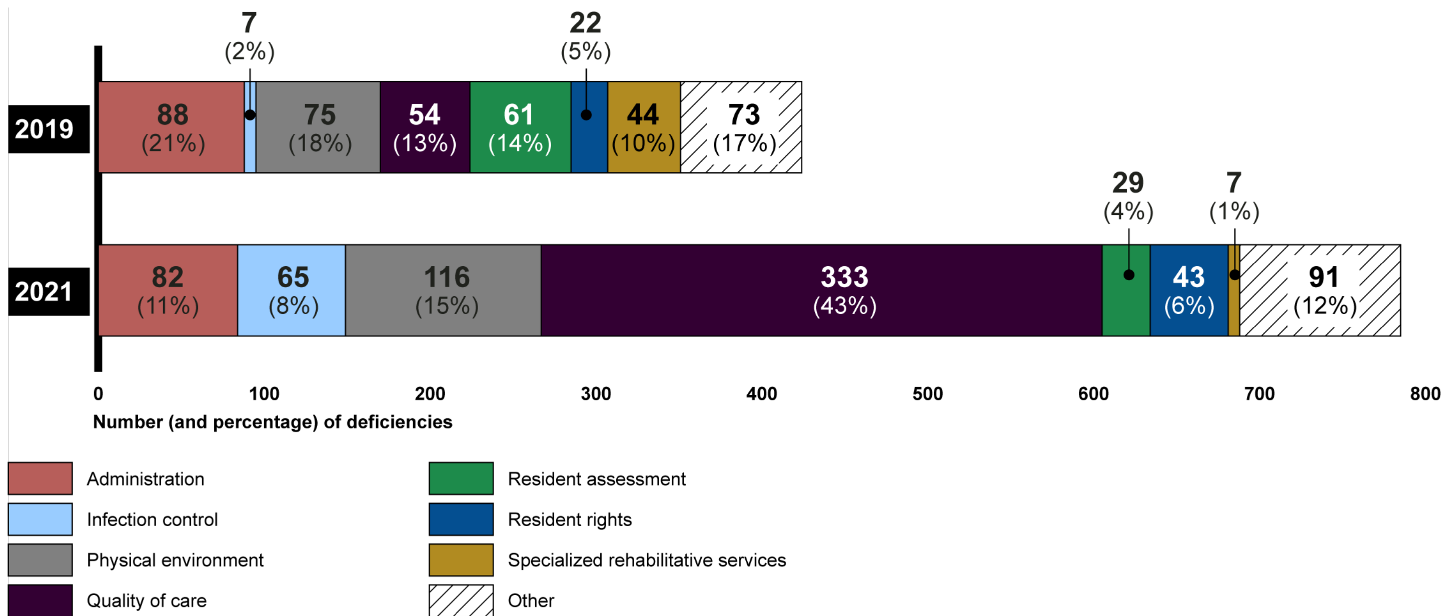
Note: Data for 2019 is from 150 annual inspections of state veterans homes; data for 2021 is from 123 inspections. As a result, the number of deficiencies reported for 2021 is fewer than what would have been found had all homes been inspected in that year. There were fewer in 2021 because 28 homes received an interim records review from VA's office of Geriatrics and Extended Care in January 2021 in lieu of an annual inspection. We were not able to include 2020 in our analysis because VA suspended all annual inspections in March 2020 in response to the COVID-19 pandemic; inspections resumed in January 2021. Isolated deficiencies affect one or a limited number of residents or a limited number of staff involved, or the situation occurred only occasionally or in a limited number of locations. Pattern deficiencies affect more than limited number of residents, or more than limited number of staff involved, or the situation occurred in several locations but the locations are not dispersed through the facility. Widespread deficiencies are pervasive (affect many locations) throughout the facility or represented systemic failure that affected or had the potential to affect a large portion or all of the facility's residents.

[a]Our review of VA's data found that some deficiencies from 2019 lacked a scope and severity rating. We labeled these deficiencies as having an "unknown severity" and "unknown scope."

In examining the types of deficiencies cited in 2019 and 2021, we found that a majority (77 percent) of the increase in deficiencies was because of increases in non-compliance with standards associated with two of the 16 categories. Specifically, quality of careNosuch as accidents and pressure soresNoand infection controlNosuch as hand hygieneNocategories. (See

appendix IV for a list of all 16 categories.) Non-compliance with quality of care standards was the fourth most common category of deficiencies in 2019 and the most common in 2021.[41] Non-compliance with infection control standards represented a small percentage of deficiencies in both years, but increased as a share of total deficiencies from 2 percent in 2019 to 8 percent in 2021 (see fig. 4).[42] State veterans homes were cited for infection control deficiencies for several reasons, including staff non-compliance with a home's hand hygiene or personal protective equipment policies.

Figure 4: Count of Deficiencies in 2019 and 2021, by Category of Deficiency



Source: GAO analysis of Department of Veteran Affairs (VA) data. | GAO-23-105167

[41]Administration, physical environment, and resident assessments were the three categories with the most deficiencies in 2019. Our review of VA data also found that 41 homes (27 percent of homes for which we had data) were cited for at least one quality of care deficiency in 2019, while 111 homes (90 percent) were cited in 2021.

[42]Our review of VA data also found that 7 homes (5 percent) were cited for one infection control deficiency in 2019, while 65 homes (53 percent) were cited in 2021.

Data table for Figure 4: Count of Deficiencies in 2019 and 2021, by Category of Deficiency

Category	2019[a]	2021[b]
Administration	88 (21%)	82 (11%)
Infection control	7 (2%)	65 (8%)
Physical environment	75 (18%)	116 (15%)
Quality of care	54 (13%)	333 (43%)
Resident assessment	61 (14%)	29 (4%)
Resident rights	22 (5%)	43 (6%)
Specialized rehabilitative services	44 (10%)	7 (1%)
Other	73 (17%)	91 (12%)

Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-23-105167

Note: Data for 2019 is from 150 annual inspections of state veterans homes; data for 2021 is from 123 inspections. As a result, the number of deficiencies reported for 2021 is fewer than what would have been found had all the homes been inspected in that year. There were fewer inspections in 2021 because 28 homes received an interim records review from VA's office of Geriatrics and Extended Care in January 2021 in lieu of an annual inspection. We were not able to include 2020 in our analysis because VA suspended all annual inspections in March 2020 in response to the COVID-19 pandemic; inspections resumed in January 2021. VA checks for compliance with 189 standards across 16 different categories. VA inspections check for 16 categories of standardsNo15 in 38 C.F.R. Part 51, Subpart D, and other standards in Subpart C, which VA has previously counted under a single category. Categories included in "other" are fiscal, admission transfer and discharge, resident behavior and facility practices, quality of life, nursing services, dietary services, physician services, dental services, and pharmacy services.

In contrast, available VA data indicated that there were fewer deficiencies in 2021 for non-compliance with certain standards, including those associated with resident assessmentNosuch as requirements for homes to develop comprehensive care plans to meet each resident's physical, mental, and psychosocial needsNoand to offer specialized rehabilitation servicesNosuch physical therapy and mental health services. For example, 29 percent of state veterans homes were cited for at least one resident assessment deficiency in 2019, while 21 percent were cited in 2021.

COVID-19 Pandemic

COVID-19 has inflicted a devastating toll on residents and staff at state veterans homes. According to VA data, 1,714 home residents and 62 home staff infected with COVID-19 have died as of July 2022.

VA officials told us that COVID-19 has had an ongoing effect on inspections and deficiencies cited, though the effect of the pandemic has not been thoroughly analyzed. According to VA officials, some measures taken by officials at state veterans homes to mitigate the effect of COVID-19 may have affected the quality of care and physical environment. For example, residents spent more time in their rooms and less time at social gatherings and dining rooms. VA officials told us the increased social isolation may have led to more falls and pressure ulcers, potentially contributing to the increase in deficiencies between 2019 and 2021.

Source: GAO analysis of Department of Veteran Affairs (VA) information. | GAO-23-105167

We also found that 54 of the 122 state veterans homes for which we had annual inspection data for both 2019 and 2021 were cited for the same deficiency, meaning they failed to meet the same standard in both years. From this group of homes with repeat deficiencies, 18 had two or more repeat deficiencies. The most common categories for repeat deficiencies were physical environment and quality of care. For example, 39 homes were cited in both years for non-compliance with applicable codes to ensure life safety from fire.[43] In addition, 9 homes were cited in both years for non-compliance with taking sufficient steps to prevent accidents, which is a standard of quality care.[44]

In addition to VA inspection data, we also reviewed CMS's Five-Star Rating System data to understand what it may reveal about state veteran home quality. CMS's quality rating system is intended to help consumers compare nursing home quality. The Five-Star Rating System assigns each nursing home participating in the Medicare or Medicaid programs an

[43]Standard 51.200(a) checks multiple systems in the facility for compliance with life fire safety codes, such as sprinklers, fire alarms, and doors. A deficiency cited may involve different codes or chapters, despite being part of the same standard.

[44]Standard 51.120(i) requires that facility management ensure the resident environment remain as free of accident hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents.

overall rating ranging from one star (much below average quality) to five stars (much above average quality).

In our review of the CMS data, we found that, of the 116 state veterans homes participating in Medicare or Medicaid in 2021, a majority had higher overall star ratings than other types of nursing homes in their state.[45] Specifically, 77 of 111 state veterans homes with star ratings scored above the median rating for other nursing homes in their state for overall quality in 2021. A nursing home's overall star rating is based on CMS data and has three components: health inspections, staffing, and quality measures. State veteran homes' performance on the staffing componentNo94 scored above their state's medianNogenerally increased the number of stars these homes received for overall quality.[46]

See appendix V for additional information about how CMS star ratings are calculated.

VA Could Enhance Its Oversight of State Veterans Homes by Improving Data Analytic Capabilities and Expanding Enforcement Options

We found that while VA captures important data on state veterans home quality through annual inspections, its ability to oversee homes' compliance with quality standards could be enhanced by improving its data analysis capabilities. We also found that VA could improve the effectiveness of corrective action plans by developing a process for following up on plans that lack evidence of timely implementation. Further, expanding its range of enforcement actions could help VA ensure state veterans home compliance with quality standards. Finally, VA is in the process of making substantial changes to how it oversees these

[45]As previously mentioned, CMS oversees more than 15,000 certified nursing homes nationwide that participate in Medicare or Medicaid.

[46]GAO and others have reported on the link between staffing levels and quality outcomes for residents. For example, GAO, *Medicare: Additional Reporting on Key Staffing Information and Stronger Payment Incentives Needed for Skilled Nursing Facilities,* GAO-21-408 (Washington, D.C.: July 9, 2021).

homes by centralizing its oversight processes; VA could help ensure this effort is successful by bringing it into alignment with VA policy.

Improving Data Analytic Capabilities Could Strengthen Ability to Oversee State Veterans Home Performance on Inspections

VA officials said that they are limited in their ability to efficiently analyze state veterans home oversight data collected and stored in a legacy data system and that current plans for the replacement data system do not ensure that the new system will have the necessary analytic capabilities to make VA's work more efficient. VA officials said they have relied on the State Home Online Survey Tool data system to store inspection related documents since 2001. According to VA officials, the data system holds copies of inspection documents, as well as corrective action plans. To analyze data from this system, VA officials told us they download individual documents and copy information into Excel spreadsheets. Once VA officials copy data into ExcelNoa time-consuming processNoVA officials said they are then able to analyze oversight data to review the state veterans homes' performance on VA inspections, such as identifying the most common categories of deficiencies.

VA officials acknowledged that the State Home Online Survey Tool they have used since 2001 is an antiquated and inefficient system, and that the agency needs to improve its data analytic capabilities. As such, GEC is in the process of replacing the tool with a new data system, which officials expect to be implemented by the end of 2022. However, according to VA officials, the new data system will not have some key analytic capabilities, such as the ability to aggregate deficiency data by facility, state, region, or survey year and track trends over time. When asked, VA officials involved in the process of implementing the new data system said they hoped to include some capabilities in future iterations of the system. However, VA officials said they did not know the extent of the analysis possibilities in the future, and officials did not provide a plan detailing the analytic capabilities VA needs to oversee state veterans homes.

Having a data system with key analytic capabilities would be consistent with VA's directive on state veterans home inspection requirements.[47]

[47]VHA Directive 1145.01.

According to the directive, the relevant data system should be used to analyze all inspection data to improve efficiency of oversight and make data available in a timely manner. Further, adding these capabilities would be consistent with VA's data enterprise strategy that calls for data analysis to be used to develop, justify, and support decision making to facilitate program evaluation and promote positive results for veterans. Until VA has a data system with necessary analytical capabilities, VA officials will not be able to efficiently perform their oversight of quality at state veterans homes.

Developing a Process for Monitoring Implementation of Corrective Action Plans Could Improve Oversight Effectiveness

We found that VA could improve the effectiveness of its oversight of corrective action plans by developing a process for following up on those that lack evidence of timely implementation. According to VA's policies, in order to receive per diem payments from VA, state veterans homes must meet all standards (full certification) or have an accepted corrective action plan for each deficiency cited during a VA inspection (provisional certification).

Before VA officials accept a home's corrective action plan as being sufficient for addressing a deficiency, officials are responsible for verifying that corrective action plan documentation identifies specific steps to correct the deficiency and a proposed date for completing these steps. To move from provisional to full certification, a state veterans home must submit evidence to VA that is has implemented its corrective action plan.

Our review of documentation for inspections completed in 2019 and 2021 found issues with VA's documentation around the implementation of these corrective action plans. Specifically, our review of 2019 inspections found that 22 percent (93) of these accepted plans remained in provisional status because they lacked evidence that the state veteran home had implemented them by the agreed upon completion date.[48]

[48]Of these 93 corrective action plans, 41 were meant to correct deficiencies that affected more than a limited number of residents or that were pervasive through the facilityNoand had a severity rating of no actual harm but with the potential for more than minimum harm. Of the 52 remaining deficiencies, two caused actual harm; 15 lacked a scope and severity rating; and 35 were isolated in scope with a severity of causing no actual harm but with the potential for more than minimum harm.

Our review of 2021 inspections found that 48 percent (228 of the 476 deficiencies with accepted corrective action plans) remained in provisional status because there was no evidence that the state veterans home had implemented steps outlined in the corrective action plan by the agreed upon completion date. Over 21 percent of these deficiencies (49 of the 228) were rated as causing actual harm, and 5 more were rated as immediate jeopardy.[49] For these 5 immediate jeopardy deficienciesNowhere noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a residentNothe corrective action plans lacked evidence that they had been implemented by the agreed upon completion date and the associated state veterans homes remained in provisional status.[50]

VA officials told us they might not have information on implementation of corrective action plans for a number of reasons, including that the local VAMC staff did not enter implementation information into VA's data system, despite the state veterans home completing the steps, or that, simply, the home had not implemented the corrective action plan by the proposed completion date. VA officials said they do not currently have a process for following up with state veterans homes about accepted corrective action plans that lack evidence after the state's agreed upon completion date. According to VA's directive, per diem payments to state veteran homes are contingent upon them meeting VA quality standards. Further, federal internal control standards state that organizations should have quality information to achieve their objectives.[51] If VA had a process for following up with state veterans homes about corrective action plans that lack evidence past the state's agreed upon completion date, it would have the information needed to better oversee quality issues in these

[49]The remaining 287 deficiencies did not have a corrective action plan in place at the time of our review. There are several reasons this information was unavailable, including that deficiencies were within the 55 business days for a state to submit a corrective action plan and for VA to accept it.

[50]State veterans homes are required to implement an acceptable abatement plan to remove the immediate threat posed by the immediate jeopardy deficiency before the survey team leaves the facility. After implementing the abatement plan, homes follow the normal process for submitting corrective action plans that will sustain improvement.

Of the remaining seven immediate jeopardy deficiencies in 2021, one had evidence that a corrective action plan had been implemented and six lacked any corrective action plan information and were near or past the maximum amount of time it takes a state veterans homes to submit a corrective action plan and VA to review and accept. In its agency comments, VA officials indicated that all 2021 inspections needing a corrective action plan have been received and approved since our analysis was completed.

[51]GAO-14-704G.

homes. Such a process, for example, could include contacting management at state veterans homes every 30 days once the state's agreed upon completion date has passed to ask why the corrective action plan lacks evidence that it has been implemented and require this information to be recorded in its data systems.

Developing a Range of Enforcement Options Could Help Ensure Compliance with Quality Standards

VA could better ensure compliance with quality standards by developing a range of enforcement options to ensure that the deficiencies identified during VA inspections are corrected. Specifically, while VA's corrective action plan process provides a framework for state veterans homes to address issues of noncompliance, homes have long-standing deficiencies that have not been corrected. According to VA, it has only one enforcement actionNowithholding of per diem paymentsNoto compel state veterans homes to make necessary corrections. VA considers this action too severe for most situations.

We found that state veterans homes had long-standing deficiencies that had not been corrected and, as such, were out of compliance and remained "provisionally certified" by VA. Provisional certification allows homes to receive per-diem payments while they address deficiencies cited in an inspection through the corrective action plan process. Under the terms of a corrective action plan, state veterans homes should be taking steps to address deficiencies cited during an inspection in order to receive full certification. However, as previously described, homes are not required to provide evidence that deficiencies have been addressed. In the event no evidence is provided, a home remains provisionally certified, and continues to receive payments from VA, despite not fully meeting the quality standards outlined by the department.[52]

[52]State veterans homes are not inspected again until their next annual inspection, unless a for-cause inspection is warranted. Between 2011 and 2019, VA completed between one and three for-cause inspections per year. VA completed nine for-cause inspections in 2020. As previously noted, VA stopped all annual inspections in March 2020 in response to the COVID-19 pandemic. According to VA officials, in 2020, for-cause inspections were scheduled instead of annual inspections due to specific requests made by VA Medical Center Directors who felt an onsite inspection was necessary. VA completed two for-cause inspections in 2021 and zero in 2022 as of July 7, 2022.

Currently, VA’s only enforcement action to get state veterans homes to correct deficiencies is to withhold per diem payments if a home is out of compliance. According to VA officials, VA has never used this enforcement action because it is considered too severe for most circumstances. VA would have to withhold the complete per-diem paymentNopartial withholding is not an optionNoand this could result in residents being transferred out of the home. Officials told us withholding the per diem would only be considered if the deficiency is egregious, the home makes no attempt to fix the deficiency, and the home has a history of well-documented non-compliance.[53] According to VA officials, it has been over a decade since the agency considered withholding a noncompliant home’s per diem.

In contrast, CMS and some states have the ability to take a variety of enforcement actions, including imposing fines of varying amounts. CMS has a rangeNofrom mild to severeNoof enforcement actions, or remedies, available to help get nursing homes in compliance (see fig. 5). These remedies are based on the scope and severity of the deficiencies, ratings that VA also uses in its inspection process. The administrator at one state veterans home illustrated the difference between VA and CMS enforcement powers, noting they were more concerned about deficiencies cited by CMS, given the monetary penalties associated with them. Additionally, according to our survey, 37 states have the ability to take enforcement actionsNoincluding issuing fines or other monetary penalties, withholding state payments of funds, and suspending admissionsNoagainst state veterans homes out of compliance with their state standards.

[53]The Secretary of VA would have to approve the withholding of per diem payments, according to VA officials.

Figure 5: Enforcement Actions Available for Department of Veterans Affairs (VA) and Centers for Medicare & Medicaid Services (CMS) for Noncompliance with Quality Standards

DEPARTMENT OF VETERANS AFFAIRS (VA)

- Withhold complete per diem payment

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- Civil monetary penalties (fines for each day or instance of noncompliance)
- Denial of payment for all newly admitted eligible residents[a]
- Directed in-service training (training to staff on a specific issue identified as a problem)
- Directed plan of correction (home has to implement specific actions according to plan developed by CMS, the state, or a temporary manager)
- State monitoring (on-site monitor in the home to achieve and maintain compliance)
- Temporary management (substitute manager appointed by the state with the authority to hire, terminate, and reassign staff; obligate funds; and alter the nursing home's procedures, as appropriate)
- Termination from the Medicare and Medicaid programs

Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-23-105167

Text for Figure 5: Enforcement Actions Available for Department of Veterans Affairs (VA) and Centers for Medicare & Medicaid Services (CMS) for Noncompliance with Quality Standards

- Department of Veterans Affairs (VA)
  - Withhold complete per diem payment
- Centers for Medicare & Medicaid Services (CMS)
  - Civil monetary penalties (fines for each day or instance of noncompliance)
  - Denial of payment for all newly admitted eligible residentsa
  - Directed in-service training (training to staff on a specific issue identified as a problem)
  - Directed plan of correction (home has to implement specific actions
  - according to plan developed by CMS, the state, or a temporary manager)
  - State monitoring (on-site monitor in the home to achieve and maintain compliance)

- Temporary management (substitute manager appointed by the state with the authority to hire, terminate, and reassign staff; obligate funds; and alter the nursing home's procedures, as appropriate)
- Termination from the Medicare and Medicaid programs

Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-23-105167

[a]CMS may also deny payment for all Medicare- or Medicaid-covered residents, but this remedy is seldom used. According to CMS, it is mindful of the potential consequences of such actions when assessing whether to impose or continue a payment suspension.

VA officials acknowledged the agency's limited options for enforcing quality standards at state veterans homes once they are provisionally certified.[54] Officials in the GEC program office told us they are considering a legislative proposal that would request from Congress authority allowing the department to impose fines or withhold a percentage of the per diem for noncompliance. However, officials did not provide any specifics about the proposal, such as other enforcement options it could entail and the quality triggers that would be used.

Seeking such authority would be consistent with one of VA's goals for the state veteran home program: that VA have tools and a process that can help assure compliance and fiscal integrity. It would also align VA's practices with those used by CMS in overseeing nursing homes. For example, CMS's statutory framework and accompanying regulations acknowledge that a range of options is important, as different factorsNoincluding the scope and severity of a deficiencyNoshould be considered when selecting a remedy that will ensure compliance with standards. For CMS, the range of options includes monetary penalties, directed training, and temporary management of the home.[55] With a range of remedies, VA would be better positioned to compel state veterans homes to address issues of noncompliance and ensure the program meets it goals.

[54]VA officials told us they are considering developing an "escalation process" for poor performing state veterans homes, which would be based on three factors: 1) severity of deficiencies cited; 2) the number of deficiencies cited, including if there was an increase in the number of deficiencies year over year; and 3) the number of repeat deficiencies year over year. However, VA did not have a timeline for implementing this process.

[55]See 42 U.S.C. §§ 1395i-3(h)(2)(B), 1396r(h)(3)(C); 42 C.F.R. § 488.406 (2021).

Following VA Policy Could Help Ensure Successful Implementation of Oversight Centralization Efforts

While GEC's efforts to centralize state veterans home oversight are promising, GEC could help ensure the successful implementation of its efforts as it moves forward by following VA's directive outlining the processes program offices must follow when developing policy or making policy changes.

In January 2022, GEC began centralizing oversight of state veterans homes by shifting responsibilities for many tasks previously conducted by the 105 representatives at the VAMC of jurisdiction to four new national program managers in its own office. For example, the national program managers are now responsible for reviewing corrective action plans and managing information in VA's data system. VA officials said that centralizing state veterans home oversight at the national level in GEC would help improve data consistency, communication, and planning. Further, all responsibilities for state veterans home oversight at VANowhich also include managing the contractors, making per diem payments, and administering state veterans home construction grantsNowould be aligned within the same national office.

The new oversight process represents a significant shift in GEC's oversight policies and affects both VA stakeholders at the VAMC-level and state veterans home stakeholders who have previously worked closely with their VAMCs of jurisdiction on VA oversight issues. However, we found that GEC has not followed VA's directive for national policy development, which requires policy owners to take certain steps for VA policy development, distribution, communication, and management. VA developed the directive for national policy development in response to being placed on our High Risk List in February 2015 for having "ambiguous policies and inconsistent processes," among other things. Specifically, VA issued a policy management directive outlining the processes program offices, such as GEC, must follow when developing policy or making policy changes.[56] In particular, VA policy development efforts should include a formal review and concurrence process when directives, such as GEC's state veterans home oversight directive, are

[56]Department of Veterans Affairs, Veterans Health Administration (VHA), *VHA Policy Management,* VHA Directive 0999 (Washington, D.C.: Mar. 29, 2022). This directive integrates policies that were in place prior to GEC's efforts to centralize its oversight of state veterans homes.

being updated or changed. Further, if policy needs to be communicated to stakeholders quickly, a VA notice may be published as an interim policy document.

When GEC began implementing this oversight change in January 2022, it used what officials described as “operating procedures” that were agreed upon in conversations with and shared in PowerPoint presentations to communicate the change with VAMC and selected stakeholders. GEC officials said they plan to make changes to directives and regulations, which are formal documents available to all stakeholders, but making these changes can be a multi-year process. For example, GEC officials indicated that they would update the VA directive with the significant changes in state veterans home oversight in the first quarter of fiscal year 2023 (9 months after the changes were operationalized) and that they anticipate submitting draft regulations to the VA Office of Regulatory Affairs by end of fiscal year 2023. Neither the PowerPoint presentations nor the conversations with VAMC and state veterans home officials meet VA’s requirements for communicating national policy, designed to avoid ambiguous and inconsistent processes.

VA’s requirements for national policy can help ensure necessary communication between VA and stakeholders. For example, if VA issued an interim notice describing the oversight changes (per the directive, a notice can be considered an interim policy document while directives are being completed), that notice would be posted internally and externally for all stakeholders to view.[57] However, as of September 2022, an interim notice has not been issued. As a result, the old directive outlining state veterans home oversight is still publicly available and the policy of record, even though it describes many processes that have since been replaced such as the roles of VAMCs, GEC, and data management. Because of this, there is a risk that state veterans home stakeholdersNoparticularly stakeholders within the 153 homesNohave inconsistent, incorrect, or incomplete information on the new oversight procedures.

When asked in September 2022 whether they were using the directive to guide the centralization efforts, VA officials said they had not been but that they would use the policy to guide their centralization efforts moving forward. Using VA policy to guide efforts moving forwardNoincluding

[57]According to VA, it worked with the National Association of State Veterans Homes as it began to implement changes and shared information at national conferences. However, without formal documentation, communication with individual state veterans homes may have been inconsistent and outside of VA’s control.

following its requirement to issue an interim notice that would publicly communicate changes to stakeholders and then pursuing in earnest the formalization of the oversight in official directives and regulationsNocould help ensure successful implementation of this effort to centralize state veterans home oversight.

Conclusions

VA conducts important oversight of state veterans homes through its inspection processes. This oversight is designed to ensure that the 14,500 veterans for whom VA pays for care live in homes that meet VA's quality standards. However, the department could enhance its oversight of state veterans homes, and VA has taken some steps to do so. VA plans to replace its antiquated data system, but it is important that the new system has the capabilities to allow for efficient analysis of state veterans home compliance with quality standards. Additionally, VA needs a process to monitor the implementation of corrective action plans so it has information on the steps homes are taking to address issues of noncompliance. VA recognizes some of its limitations in ensuring state veterans homes comply with its quality standards and is considering making legislative requests for additional enforcement authorities. As CMS has, VA may find that a range of enforcement actions allow for remedies to be tailored to the scope and severity of cited deficiencies. Finally, VA has taken important steps to centralize its oversight of state veterans homes for improved consistency in the process. Appropriately documenting and communicating the changes to stakeholders, as required by VA policy, would help to ensure successful implementation of these changes.

Recommendations for Executive Action

We are making the following four recommendations to VA:

The Under Secretary of Health should develop a plan to ensure the data system it is currently developing has the capabilities to aggregate and analyze state veterans home data by multiple units of measurement, including by state and home, and across survey years. (Recommendation 1)

The Under Secretary of Health should implement a process for consistently following up with state veterans homes that have not

implemented their corrective active plans by the agreed upon dates. (Recommendation 2)

The Under Secretary of Health should identify additional enforcement actions that would help ensure state veterans home compliance with quality standards and seek legislative authority to implement those actions, as appropriate. (Recommendation 3)

The Under Secretary of Health should ensure GEC's centralization efforts align with VA's policies for national policy management, such as by issuing an interim notice to communicate the oversight changes to all stakeholders and pursuing the expeditious formalization of the new oversight in official directives and regulations. (Recommendation 4)

Agency Comments and Our Evaluation

We provided a draft of this report to VA for review and comment. In written comments provided by VA (reproduced in appendix VI), VA generally agreed with our findings and concurred with our recommendations.

Specifically, VA concurred in principle with our recommendation that it develop a plan to ensure its data systems has the capabilities to aggregate and analyze state veterans homes inspection data. VA noted that it may need to request funding if the newly developed integrated operational platform does not have this technical capability.

VA concurred with the remaining three recommendations. VA officials said they would update the standard operating procedures to outline a process to ensure follow up with state veterans homes that have not implemented their corrective action plans and update its internal tracking documents to include this information so VA's national program managers will be alerted if evidence is not submitted.

To address our recommendation that VA identify additional enforcement actions that would help ensure state veterans homes' compliance with quality standards and seek legislative authority to implement those actions, VA indicated that it planned to create a legislative proposal to include enforcement actions that would be based on the level and severity of noncompliance. VA would also make any necessary updates to its regulations.

Finally, VA indicated that it would issue an interim notice on its oversight changes to address our recommendation. Once formal rulemaking has been implemented, VA will make changes to its directive and regulations.

VA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at SilasS@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix VII.

Sharon M. Silas
Director, Health Care

List of Addressees

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Martin T. Heinrich
Chairman
The Honorable John Boozman
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Debbie Wasserman Schultz
Chairwoman
The Honorable John R. Carter
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
House of Representatives

The Honorable Chris Pappas
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Robert P. Casey, Jr.
United States Senate

The Honorable Edward J. Markey
United States Senate

The Honorable Pat Toomey
United States Senate

The Honorable Elizabeth Warren
United States Senate

Appendix I: Federal Oversight of State Veterans Homes

The Department of Veterans Affairs (VA) is the only federal entity to conduct oversight of all state veterans homes. The Centers for Medicare & Medicaid Services (CMS) conducts additional oversight in the nearly 76 percent of state veterans homes that provide nursing home care and receive Medicare or Medicaid payments. In general, VA used the CMS model for developing its inspection methods according to VA documents, but the two agencies' oversight methods have some differences. See table 1 below for a description of the methods VA and CMS use in their oversight of state veterans homes. Applicable terms, where they differ, appear in bold in the table below.

Table 1: Federal State Veterans Home Oversight Methods Used by the Department of Veterans Affairs (VA) and the Centers for Medicare & Medicaid Services (CMS)

Oversight method	VA description	CMS description
Initial certification	• **Recognition Survey** is a home's first VA inspection • Required to be eligible to receive payments from VA • Review requirements related to the appropriate level of care standards • Reviews compliance with federal, state, and local laws and relevant professional standards	• **Certification Survey** is a home's first CMS inspection • Required to be eligible to receive payments from CMS • Focuses on residents and the structural requirements that relate to qualification standards
Recurring inspection	• **Annual Survey** occurs on a regular schedule, approximately yearly • Verifies state veterans homes' eligibility to continue to receive VA payments • Checks compliance with 189 standards across 16 categories, such as quality of care and a fiscal component	• **The Standard Survey** occurs every 15 months or less • Checks compliance with standards that are grouped into 22 categories, such as resident rights, quality of life, resident assessment, quality of care, and administration; no fiscal component[a]
Inspections on particular area(s) of concern	• **For-Cause Surveys** are a full inspection, but focus on specific events that prompted the inspection • Typically reviews a significant concern, or a series of incidents, complaints, deficiencies, or events that may jeopardize the health or safety of residents	• **Abbreviated Standard Surveys** do not include all aspects of the Standard Survey • Focus on particular tasks that relate to, for example, complaints received or a change of ownership, management, or director of nursing.

Oversight method	VA description	CMS description
Consequences of not meeting standards	• State veterans homes receive a deficiency for any standard that is "not met" during any inspection • Deficiency is rated for its scope and severity using a matrix adapted from CMS[b] • Home is notified of any deficiencies within 20 business days of the end of the inspection	• **Extended Survey** conducted within 14 days after completing the Standard Survey if substandard quality of care was found during the Standard Survey • Partial Extended Survey conducted if substandard quality of care was found during an Abbreviated Standard Survey or revisit (see below) that was not previously identified
Tracking of deficiencies and outcomes (For deficiencies that do not pose immediate jeopardy to resident health or safety)	• VA medical facility of jurisdiction requests the state veterans home to submit a Corrective Action Plan to address any identified deficiencies, no later than 20 business days upon receipt of the letter • VA reviews and approves the plans for each deficiency • If the plan is not acceptableNobecause it does not address the deficiency or cannot be completed in a reasonable time periodNothen the home submits a revised plan • Provisional certification granted when VA has approved the plan • Full certification granted when VA receives evidence from the home that the plan was implemented	• CMS issues Statement of Deficiencies and Plan of Correction (Form CMS-2567) to the state veterans home that includes summary of deficiencies cited • Home uses the same form to submit plan to correct the deficiency • **Post-Survey Revisit** verifies correction of deficiencies cited in a prior inspection • Enforcement actions for continued noncompliance include: • Continued noncompliance after 3 months from the date of the inspection that first determined noncompliance must result in denial of payments for new admissions • Continued noncompliance after 6 months from the date of the inspection that first determined noncompliance results in termination of provider agreements
Tracking of deficiencies that pose immediate jeopardy	• Findings shared with VA's Office of Geriatrics and Extended Care, which will determine if the findings indicate an immediate jeopardy situation within an hour of receiving the information • After determination, the VA inspection team is not allowed to leave the home until the home submits an acceptable corrective action plan to abate it	• May be identified during standard, abbreviated standard, extended, or partial extended surveys • If immediate jeopardy is not removed, termination and/or temporary management will be imposed in as few as 2 calendar days after the inspection which determined immediate jeopardy and provider agreement must be terminated no later than 23 calendar days from the last day of the inspection • The home submits an allegation that the immediate jeopardy has been removed and describes how the immediate jeopardy has been addressed so that removal of the immediate jeopardy can be verified onsite • (See "penalties/enforcement actions" below for more about CMS' immediate jeopardy actions)
Penalties/ enforcement actions	• According to VA officials: • Withhold per-diem payments if • deficiency is egregious, • the home makes no attempt to fix the deficiency, • and the home has a history of well-documented non-compliance • VA Secretary must approve such an action	• Penalties imposed for deficiencies vary based on factors including whether a deficiency is classified as causing immediate jeopardy to resident health or safety • Daily or per instance penalties for deficiencies imposed • Higher daily penalties for deficiencies with immediate jeopardy • Payments may be denied for new admissions for continued noncompliance

Oversight method	VA description	CMS description
Public reporting	• Information on the quality of all state veterans homes not publicly available[c]	• Each nursing home has a five-star quality rating which is publicly reported on Nursing Home Care Compare website, among other information[d] • Ratings have three componentsNoinspections, quality measures, and staffing measuring (staffing levels and staffing turnover)Noand an overall quality rating
Oversight of contractors (VA) and state inspection agencies (CMS)	• Among other things, VA's contract stipulates that: • 10 percent of inspections have VA direct observations, • VA samples 50 percent of inspection reports and reviews for any needed corrections; • VA validates 90 percent of inspection reports for timely submission; • VA reviews monthly status reports and quarterly reports from the contractor to assure they include all needed elements; and • VA reviews any feedback that homes provide on the inspection process	• Conducts comparative inspections of some nursing homes to compare its results to the state agency's results • May accompany state inspectors to directly observe them during inspectionsNoto evaluate the performance and ability to document inspection deficiencies

Source: GAO analysis of VA and CMS information. | GAO-23-105167

[a]See 42 C.F.R. Part 483, Subpart B (2021).

[b]Completed VA inspections, and all supporting documentation, are stored in a database, the State Home Online Survey Tool. "Scope" generally refers to whether the deficiency is isolated to one patient or widespread, and "severity" generally refers to whether the deficiency can cause injury, harm, impairment, or death.

[c]GAO previously recommended that VA should provide publicly available information on all state veterans homesNoinformation that it has available for other nursing home settings. See GAO-19-428.

[d]See Centers for Medicare & Medicaid Services, *Nursing Home Care Compare* website, accessed July 27, 2022, https://www.medicare.gov/care-compare/. Additionally, the state agency must make Form CMS-2567 available with noted deficiencies and corrective action plans, as well as separate listings of any notice of isolated deficiencies, within 14 days of a request for the information.

Appendix II: State Veterans Homes That Provide Nursing Home Care In All 50 States and Puerto Rico

To obtain information about state veterans homes that provide nursing home care in each state, we conducted a national survey (March through April 2022) to officials from state agencies that operate state veterans homes in all 50 states and Puerto Rico (Washington, D.C., does not have any of these homes). Table 2 lists information respondents provided in the survey about all 153 state veterans homes that provide nursing home care and were recognized by the Department of Veterans Affairs as of the date of survey completion, including their location, number of nursing home beds, whether they are certified by the Centers for Medicare & Medicaid Services (CMS), and whether they are managed directly by the state or by a contractor.[1]

Table 2: States' Responses to GAO Survey Questions on Information About State Veterans Homes Providing Nursing Home Care in Each State, as of March-April 2022

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
Alabama	Bill Nichols State Veterans Home	Alexander City	No	Contractor	No	150
	Colonel Robert L. Howard State Veterans Home	Pell City	No	Contractor	No	174
	Floyd E. "Tut" Fann State Veterans Home	Huntsville	No	Contractor	No	150
	William F. Green State Veterans Home	Bay Minette	No	Contractor	No	150
Alaska	Alaska Veterans' & Pioneers' Home	Palmer	No	State	No	14

[1]The table is accurate for each state as of the date they completed their survey in March-April 2022. We excluded state veterans homes states reported that either do not provide nursing home care (i.e., state veterans homes that provide domiciliary care only) or that were not operational and recognized by the Department of Veterans Affairs as of the date of survey completion.

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
Arizona	Phoenix State Veteran Home	Phoenix	Yes	State	No	200
	Tucson State Veteran Home	Tucson	Yes	State	Yes	120
Arkansas	Arkansas State Veterans Home at Fayetteville	Fayetteville	Yes	State	No	90
	Arkansas State Veterans Home at Little Rock	Little Rock	Yes	State	No	96
California	Veterans Home of California - Barstow	Barstow	Yes	State	No	100
	Veterans Home of California - Chula Vista	Chula Vista	Yes	State	No	180
	Veterans Home of California - Fresno	Fresno	Yes	State	No	120
	Veterans Home of California - Redding	Redding	Yes	State	No	60
	Veterans Home of California - West Los Angeles	Los Angeles	Yes	State	No	312
	Veterans Home of California - Yountville	Yountville	Yes	State	No	336
Colorado	Bruce McCandless VCLC	Florence	Yes	State	No	105
	Spanish Peaks VCLC	Walsenburg	Yes	Contractor	No	120
	VCLC at Fitzsimons	Aurora	Yes	State	No	180
	VCLC at Homelake	Monte Vista	Yes	State	No	60
	VCLC at Rifle	Rifle	Yes	State	No	89
Connecticut	Department of Veterans Affairs	Rocky Hill	Yes	State	No	125
Delaware	Delaware Veteran's Home	Milford	Yes	State	No	144
Florida	Baldomero Lopez State Veterans' Nursing Home	Land O' Lakes	Yes	State	No	120
	Chester Sims State Veterans' Nursing Home	Panama City	Yes	State	No	120
	Clyde E. Lassen State Veterans' Nursing Home	St. Augustine	Yes	State	No	120
	Douglas Jacobson State Veterans' Nursing Home	Port Charlotte	Yes	State	No	120
	Emory Bennett State Veterans' Nursing Home	Daytona Beach	Yes	State	No	120

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
	Sandy Nininger State Veterans' Nursing Home	Pembroke Pines	Yes	State	No	120
Georgia	Georgia War Veterans Home	Milledgeville	No	Contractor	Yes	375
	Georgia War Veterans Nursing Home	Augusta	No	State	Yes	192
Hawaii	Yukio Okutsu State Veterans Home	Hilo	Yes	Contractor	No	95
Idaho	Idaho State Veterans Home - Boise	Boise	Yes	State	No	122
	Idaho State Veterans Home - Lewiston	Lewiston	Yes	State	No	66
	Idaho State Veterans Home - Pocatello	Pocatello	Yes	State	No	66
Illinois	Illinois Veterans' Home at Anna	Anna	No	State	No	49
	Illinois Veterans' Home at LaSalle	LaSalle	No	State	No	190
	Illinois Veterans' Home at Manteno	Manteno	No	State	No	294
	Illinois Veterans' Home at Quincy	Quincy	No	State	No	382
Indiana	Indiana Veterans Home	West Lafayette	Yes	State	No	212
Iowa	Iowa Veterans Home	Marshalltown	Yes	State	No	387
Kansas	Kansas Soldiers Home	Fort Dodge	Yes	State	No	56
	Kansas Veterans Home	Winfield	Yes	State	No	97
Kentucky	Carl M Brashear Radcliff Veterans Center	Radcliff	Yes	State	No	120
	Joseph E. Ballard Western Kentucky Veterans Center	Hanson	Yes	State	No	156
	Paul E Patton Eastern Kentucky Veterans Center	Hazard	Yes	State	No	120
	Thomson-Hood Veterans Center	Wilmore	Yes	State	No	285
Louisiana	Louisiana Veterans Home	Jackson	Yes	State	No	129
	Northeast LA Veterans Home	Monroe	Yes	State	No	156
	Northwest LA Veterans Home	Bossier City	Yes	State	No	156

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
	Southeast LA Veterans Home	Reserve	Yes	State	No	156
	Southwest LA Veterans Home	Jennings	Yes	State	No	156
Maine	Maine Veterans' Home - Augusta	Augusta	Yes	State	No	108
	Maine Veterans' Home - Bangor	Bangor	Yes	State	No	120
	Maine Veterans' Home - Caribou	Caribou	Yes	State	No	40
	Maine Veterans' Home - Scarborough	Scarborough	Yes	State	No	120
	Maine Veterans' Home - South Paris	South Paris	Yes	State	No	62
Maryland	Charlotte Hall Veterans Home	Charlotte Hall	Yes	Contractor	No	318
Massachusetts	Soldiers Home in Chelsea	Chelsea	Yes	State	Yes	189
	Soldiers Home in Holyoke	Holyoke	No	State	Yes	234
Michigan	Michigan Veteran Homes - D.J. Jacobetti	Marquette	Yes	State	No	184
	Michigan Veteran Homes at Grand Rapids	Grand Rapids	Yes	State	No	128
	Michigan Veteran Homes at Chesterfield Township	Chesterfield Township	Yes	State	No	128
Minnesota	MN State Veterans Home - Minneapolis	Minneapolis	Yes	State	No	350
	MN State Veterans Home - Fergus Falls	Fergus Falls	Yes	State	No	106
	MN State Veterans Home - Luverne	Luverne	Yes	State	No	85
	MN State Veterans Home - Silver Bay	Silver Bay	Yes	State	No	83
Mississippi	Mississippi Veterans Home at Collins	Collins	No	State	No	150
	Mississippi Veterans Home at Jackson	Jackson	No	State	No	150
	Mississippi Veterans Home at Kosciusko	Kosciusko	No	State	No	150
	Mississippi Veterans Home at Oxford	Oxford	No	State	No	150

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
Missouri	Missouri Veterans Home - Cameron	Cameron	No	State	No	200
	Missouri Veterans Home - Cape Girardeau	Cape Girardeau	No	State	No	150
	Missouri Veterans Home - Mexico	Mexico	No	State	No	150
	Missouri Veterans Home - Mt. Vernon	Mt Vernon	No	State	No	200
	Missouri Veterans Home – St. James	St James	No	State	No	150
	Missouri Veterans Home – St. Louis	St Louis	No	State	No	188
	Missouri Veterans Home - Warrensburg	Warrensburg	No	State	No	200
Montana	Eastern Montana Veterans Home	Glendive	Yes	Contractor	No	80
	Montana Veteran's Home	Columbia Falls	Yes	State	No	105
	Southwest Montana Veterans Home	Butte	Yes	Contractor	No	60
Nebraska	Central Nebraska Veterans Home	Kearney	No	State	No	225
	Eastern Nebraska Veterans Home	Bellevue	No	State	No	120
	Norfolk Veterans Home	Norfolk	No	State	No	159
	Western Nebraska Veterans Home	Scottsbluff	No	State	No	62
Nevada	Northern Nevada State Veterans Home	Sparks	Yes	Contractor	No	96
	Southern Nevada State Veterans Home	Boulder City	Yes	State	No	180
New Hampshire	New Hampshire Veterans Home	Tilton	No	State	No	250
New Jersey	Menlo Park Veterans Home	Edison	Yes	State	No	328
	Paramus Veterans Home	Paramus	Yes	State	No	336
	Vineland Veterans Home	Vineland	Yes	State	No	330
New Mexico	Fort Bayard State Veterans' Home	Silver City	Yes	State	No	40
	New Mexico State Veterans' Home	Truth or Consequences	Yes	State	No	135

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
New York	Long Island State Veterans Home	Stony Brook	Yes	State	No	350
	NYS Veterans Home at Batavia	Batavia	Yes	State	No	126
	NYS Veterans Home at Montrose	Montrose	Yes	State	No	252
	NYS Veterans Home at Oxford	Oxford	Yes	State	No	242
	NYS Veterans Home, St. Albans	Jamaica	Yes	State	No	250
North Carolina	Black Mountain State Veterans Home	Black Mountain	Yes	Contractor	Yes	100
	Fayetteville State Veterans Home	Fayetteville	Yes	Contractor	Yes	150
	Kinston State Veterans Home	Kinston	Yes	Contractor	Yes	100
	Salisbury State Veterans Home	Salisbury	Yes	Contractor	Yes	99
North Dakota	ND Veterans Home	Lisbon	Yes	State	No	52
Ohio	Ohio Veterans Home	Georgetown	Yes	State	No	168
	Ohio Veterans Home	Sandusky	Yes	State	No	427
Oklahoma	Ardmore Veterans Center	Ardmore	No	State	No	175
	Claremore Veterans Center	Claremore	No	State	No	302
	Clinton Veterans Center	Clinton	No	State	No	148
	Lawton/Fort Sill Veterans Center	Lawton	No	State	No	200
	Norman Veterans Center	Norman	No	State	No	301
	Sulphur Veterans Center	Sulphur	No	State	No	122
	Talihina Veterans Center	Talihina	No	State	No	175
Oregon	Oregon Veterans' Home Lebanon	Lebanon	Yes	Contractor	No	154
	Oregon Veterans' Home The Dalles	The Dalles	Yes	Contractor	No	151
Pennsylvania	Delaware Valley Veterans Home	Philadelphia	Yes	State	No	130
	Gino Merli Veterans Center	Scranton	Yes	State	No	196
	Hollidaysburg Veterans Home	Hollidaysburg	Yes	State	No	257

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
	Pennsylvania Soldiers & Sailors Home	Erie	Yes	State	No	107
	Southeastern Veterans Center	Spring City	Yes	State	No	238
	Southwestern Veterans Center	Pittsburgh	Yes	State	No	236
Puerto Rico	La Casa Del Veterano	Juana Diaz	No	Contractor	No	120
Rhode Island	RI Veterans Home	Bristol	No	State	No	192
South Carolina	CM Tucker Jr Nursing Care Center E. Roy Stone Pavilion	Columbia	Yes	State	No	90
	Richard M Campbell Veterans Nursing Home	Anderson	Yes	Contractor	No	220
	Veterans' Victory House	Walterboro	Yes	Contractor	No	220
South Dakota	Michael J Fitzmaurice State Veterans Home	Hot Springs	Yes	State	No	78
Tennessee	Ben Atchley State Veterans Home	Knoxville	Yes	State	No	140
	Brigadier General Wendell H. Gilbert Tennessee State Veterans Home	Clarksville	Yes	State	No	108
	Tennessee State Veterans Home - Murfreesboro	Murfreesboro	Yes	State	No	140
	William D. Manning Tennessee State Veterans Home	Humboldt	Yes	State	No	140
Texas	Alfredo Gonzalez Texas State Veterans Home	McAllen	Yes	Contractor	No	160
	Ambrosio Guillen Texas State Veterans Home	El Paso	Yes	Contractor	No	160
	Clyde W. Cosper Texas State Veterans Home	Bonham	Yes	Contractor	No	160
	Frank M. Tejeda Texas State Veterans Home	Floresville	Yes	Contractor	No	160
	Lamen-Lusk-Sanchez Texas State Veterans Home	Big Spring	Yes	Contractor	No	160
	Richard A. Anderson Texas State Veterans Home	Houston	Yes	Contractor	No	120

State	State veterans home name	State veterans home location	Certified by CMS	Managed by state agency or contractor	Accredited by Joint Commission[a]	Number of nursing home beds
	Ussery-Roan Texas State Veterans Home	Amarillo	Yes	Contractor	No	120
	Watkins-Logan Texas State Veterans Home	Tyler	Yes	Contractor	No	100
	William R. Courtney Texas State Veterans Home	Temple	Yes	Contractor	No	160
Utah	George E. Wahlen Ogden Veterans Home	Ogden	Yes	Contractor	No	120
	Mervyn Sharp Bennion Veterans Home	Payson	Yes	Contractor	No	108
	Southern Utah Veterans Home	Ivins	Yes	Contractor	No	108
	William E. Christoffersen Veterans Home	Salt Lake City	Yes	Contractor	No	81
Vermont	Vermont Veterans Home	Bennington	Yes	State	No	130
Virginia	Sitter & Barfoot Veterans Care Center	Richmond	Yes	State	No	200
	Virginia Veterans Care Center	Roanoke	Yes	State	No	196
Washington	Spokane Veterans Home	Spokane	Yes	State	No	100
	Walla Walla Veterans Home	Walla Walla	Yes	State	No	80
	Washington Soldiers Home	Orting	Yes	State	No	97
	Washington Veterans Home	Port Orchard	Yes	State	No	240
West Virginia	WV Veterans Nursing Facility	Clarksburg	No	State	No	120
Wisconsin	Wisconsin Veterans Home Chippewa Falls	Chippewa Falls	Yes	Contractor	No	72
	Wisconsin Veterans Home King	King	Yes	State	No	521
	Wisconsin Veterans Home Union Grove	Union Grove	Yes	State	No	158

Source: GAO. | GAO-23-105167

Note: We excluded state veterans homes states reported that either do not provide nursing home care (i.e., state veterans homes that provide domiciliary care only) or that were not operational and recognized by the Department of Veterans Affairs as of the date of survey completion. Additionally, Wyoming is excluded from this table because the state reported not having any state veterans homes that provide nursing home care.

[a]The Joint Commission is a nonprofit organization that provides voluntary health care accreditation for hospitals using standards that address a facility’s level of performance in areas such as patient rights, patient treatment, and infection control.

Appendix III: State Policies for State Veterans Home Oversight and Summary of These Homes in Each State

To obtain information that included state-specific policies for state veterans home oversight, we conducted a national survey (March through April 2022) of officials from state agencies that operate state veterans homes in all 50 states and Puerto Rico. Table 3 shows policies that officials in each state reported their state has for oversight of their state veterans homes that provide nursing home care, and it has summary information about all state veterans homes in each state.

Table 3: States' Responses to GAO Survey Questions on State Policies for State Veterans Home Oversight and Summary of State Veterans Homes in Each State

	State oversight policies					State veterans homes		
State	Requires license for state veterans home administrators	Has state-specific regulations for nursing home quality	Conducts state-specific for-cause inspections	Requires state-specific corrective action plans	Has ability to take at least one type of enforcement action[a]	Number providing nursing home care	Number managed by contractor[b]	Number certified by Centers for Medicare & Medicaid Services
AK	Yes	No	Yes	Yes	No	1	0	0
AL	Yes	Yes	Yes	Yes	Yes	4	4	0
AR	Yes	Yes	Yes	Yes	Yes	2	0	2
AZ	Yes	Yes	No	Yes	No	2	0	2
CA	No	Yes	Yes	Yes	Yes	6	0	6
CO	Yes	Yes	Yes	Yes	Yes	5	1	5
CT	Yes	Yes	Yes	Yes	Yes	1	0	1
DE	Yes	Yes	Yes	Yes	Yes	1	0	1
FL	Yes	Yes	Yes	Yes	Yes	6	0	6
GA	Yes	Yes	Yes	Yes	Yes	2	1	0
HI	Yes	Yes	Yes	Yes	Yes	1	1	1
IA	Yes	No	Yes	Yes	Yes	1	0	1
ID	Yes	Yes	No	No	Yes	3	0	3
IL	Yes	No	Yes	Yes	Yes	4	0	0

	State oversight policies					State veterans homes		
State	Requires license for state veterans home administrators	Has state-specific regulations for nursing home quality	Conducts state-specific for-cause inspections	Requires state-specific corrective action plans	Has ability to take at least one type of enforcement action[a]	Number providing nursing home care	Number managed by contractor[b]	Number certified by Centers for Medicare & Medicaid Services
IN	Yes	Yes	Yes	Yes	Yes	1	0	1
KS	Yes	No	Yes	Yes	No	2	0	2
KY	Yes	No	Yes	Yes	Yes	4	0	4
LA	Yes	No	No	N/A[c]	N/A	5	0	5
MA	No	Yes	Yes	Yes	Yes	2	0	1
MD	Yes	Yes	Yes	Yes	Yes	1	1	1
ME	Yes	Yes	Yes	Yes	Yes	5	0	5
MI	Yes	Yes	No	Yes	Yes	3	0	3
MN	Yes	No	No	N/A	N/A	4	0	4
MO	Yes	No	No	N/A	N/A	7	0	0
MS	Yes	Yes	Yes	Yes	Yes	4	0	0
MT	Yes	No	Yes	Yes	Yes	3	2	3
NC	Yes	No	Yes	Yes	Yes	4	4	4
ND	Yes	Yes	Yes	Yes	Yes	1	0	1
NE	Yes	Yes	Yes	Yes	Yes	4	0	0
NH	Yes	No	No	N/A	N/A	1	0	0
NJ	Yes	Yes	Yes	Yes	Yes	3	0	3
NM	Yes	No	No	N/A	N/A	2	0	2
NV	Yes	No	No	N/A	N/A	2	1	2
NY	Yes	Yes	Yes	Yes	Yes	5	0	5
OH	Yes	Yes	Yes	Yes	Yes	2	0	2
OK	Yes	No	Yes	Yes	No	7	0	0
OR	Yes	Yes	No	Yes	Yes	2	2	2
PA	Yes	Yes	Yes	Yes	Yes	6	0	6
PR	Yes	Yes	Yes	Yes	Yes	1	1	0
RI	Yes	No	Yes	Yes	Yes	1	0	0
SC	Yes	Yes	Yes	Yes	Yes	3	2	3
SD	Yes	Yes	Yes	Yes	Yes	1	0	1
TN	Yes	Yes	Yes	Yes	Yes	4	0	4
TX	Yes	Yes	Yes	Yes	Yes	9	9	9
UT	Yes	No	No	N/A	N/A	4	4	4
VA	Yes	Yes	Yes	Yes	No	2	0	2
VT	Yes	Yes	Yes	No	Yes	1	0	1

	State oversight policies					State veterans homes		
State	Requires license for state veterans home administrators	Has state-specific regulations for nursing home quality	Conducts state-specific for-cause inspections	Requires state-specific corrective action plans	Has ability to take at least one type of enforcement action[a]	Number providing nursing home care	Number managed by contractor[b]	Number certified by Centers for Medicare & Medicaid Services
WA	Yes	Yes	Yes	Yes	Yes	4	0	4
WI	Yes	No	Yes	Yes	No	3	1	3
WV	Yes	Yes	Yes	Yes	Yes	1	0	0
WY	N/A[d]	N/A	N/A	N/A	N/A	0	0	0

Legend: N/A = not applicable

Source: GAO. | GAO-23-105167

[a]See Table 4 for more information about enforcement actions available to the states as reported in the survey.

[b]The state veterans homes not reported as contractor-managed were reported to be managed by a state agency.

[c]State-specific corrective action plans and enforcement actions do not apply to the seven states that reported they do not have state-specific nursing home quality regulations or for-cause surveysNoLouisiana, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, and Utah.

[d]The state oversight questions do not apply to Wyoming because it reported not having any state veterans homes that provide nursing home care.

Of the 43 states that reported assessing state-specific nursing home quality regulations and/or conducting their own for-cause inspections, 37 states reported they have the option to take one or more enforcement actions if a state veterans home does not meet state standards. Table 4 shows each state's response to which enforcement actions, if any, are available to their state.

Table 4: Survey Responses on Enforcement Actions Available to the States for Conducting Oversight of State Veterans Homes

State	None	Issue fines and/or monetary penalties	Withhold state payments/funds	Suspend admissions	Managed temporarily by a different state agency	Close the home	Other
AK	Yes	No	No	No	No	No	No
AL	No	No	No	No	No	Yes	Probational license or termination of license.
AR	No	Yes	No	No	No	No	No
AZ	Yes	No	No	No	No	No	No
CA	No	Yes	Yes	Yes	No	Yes	No
CO	No	No	No	No	Yes	Yes	No

State	None	Issue fines and/or monetary penalties	Withhold state payments/funds	Suspend admissions	Managed temporarily by a different state agency	Close the home	Other
CT	No	Yes	No	Yes	No	Yes	No
DE	No	Yes	Yes	Yes	Yes	Yes	No
FL	No	Yes	Yes	Yes	No	Yes	No
GA	No	Yes	Yes	Yes	Yes	Yes	No
HI	No	Yes	Yes	Yes	No	Yes	No
IA	No	Yes	Yes	Yes	Yes	Yes	No
ID	No	No	No	No	No	No	Revoke license. Also issue fine and/or imprisonment for operating a facility without a license
IL	No	Yes	Yes	Yes	No	No	No
IN	No	Yes	Yes	Yes	No	No	No
KS	Yes	No	No	No	No	No	No
KY	No	Yes	No	No	No	Yes	No
MA	No	No	No	Yes	No	Yes	No
MD	No	Yes	Yes	Yes	Yes	Yes	No
ME	No	No	No	No	Yes	Yes	Take away license
MI	No	No	No	No	No	No	Revoke license to operate as a skilled nursing facility
MS	No	No	No	Yes	No	Yes	No
MT	No	Yes	Yes	No	No	No	No
NC	No	Yes	No	No	No	No	No
ND	No	Yes	No	No	No	No	No
NE	No	Yes	No	Yes	Yes	Yes	No
NJ	No	Yes	No	Yes	Yes	Yes	No
NY	No	Yes	Yes	Yes	No	Yes	No
OH	No	Yes	Yes	Yes	Yes	Yes	No
OK	Yes	No	No	No	No	No	No

State	None	Issue fines and/or monetary penalties	Withhold state payments/funds	Suspend admissions	Managed temporarily by a different state agency	Close the home	Other
OR	No	Yes	Yes	Yes	No	Yes	Managed temporarily by a contractor; and applying other restrictions such as total number of residents
PA	No	Yes	Yes	Yes	Yes	Yes	No
PR	No	Yes	No	Yes	Yes	Yes	No
RI	No	Yes	Yes	Yes	No	Yes	No
SC	No	Yes	Yes	Yes	No	Yes	No
SD	No	Yes	Yes	Yes	Yes	Yes	No
TN	No	Yes	Yes	Yes	Yes	Yes	No
TX	No	Yes	Yes	Yes	Yes	Yes	No
VA	Yes	No	No	No	No	No	No
VT	No	Yes	Yes	Yes	Yes	Yes	No
WA	No	Yes	Yes	Yes	Yes	No	No
WI	Yes	No	No	No	No	No	No
WV	No	Yes	No	Yes	No	Yes	No
Totals	**6**	**30**	**21**	**27**	**16**	**28**	No

Legend:

Yes = The state indicated having the ability to take the enforcement action.

No = The state indicated not having the ability to take the enforcement action, or it indicates “not applicable.”

Source: GAO | GAO-23-105167

Note: The seven states that reported having neither state-specific nursing home quality regulations nor for-cause inspections are excluded from this tableNoLouisiana, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, and Utah. Wyoming is also excluded since the state reported not having any state veterans homes that provide nursing home care.

Appendix IV: Categories of Standards Assessed during VA's Annual Inspection of State Veterans Homes

Table 5: Categories of Standards Assessed during VA's Annual Inspection of State Veterans Homes

Category	Number of standards	Example
Fiscal	23	Submitting the correct form to VA each month to receive per diem payments
Resident rights	23	Putting the results of VA's inspection in a place that is readily accessible to residents
Admission, transfer, and discharge	11	Notifying the resident and, if known, a family member or legal representative prior to transferring or discharging a resident
Resident behavior and facility practices	6	The inappropriate use of a sedating psychotropic drug to manage or control behavior
Quality of life	19	Establishing a council of residents that meet at least quarterly
Resident assessment	11	Comprehensive assessments that include describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity
Quality of care	20	Preventing and treating pressure sores
Nursing services	5	Providing registered nurses 24 hours per day, 7 days per week
Dietary services	8	Employing a qualified dietician on a full-time, part-time, or on a consultant basis
Physician services	6	Providing or arranging for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency
Specialized rehabilitative services	2	Providing specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care
Dental services	1	Arranging for transportation to and from dental services
Pharmacy services	6	Licensed pharmacist reviews each resident's drug regiment at least once a month
Infection control	3	Establishing and maintaining an infection control program
Physical environment	12	Maintaining an effective pest control program
Administration	33	Having detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents

Source: GAO analysis of Department of Veteran Affairs (VA) data. | GAO-22-105167

Appendix IV: Categories of Standards Assessed during VA’s Annual Inspection of State Veterans Homes

Note: VA inspections check for 16 categories of standardsNo15 in 38 C.F.R. Part 51, Subpart D, and other standards in Subpart C, which VA has previously counted under a single category.

Appendix V: How CMS Calculates a Nursing Home's Overall Star Rating

A nursing home's overall star rating is based on Centers for Medicare & Medicaid (CMS) data and has three components: health inspections, staffing, and quality measures. Specifically, a home's overall star rating is calculated by taking the home's performance (star rating) on the health inspection and adding or subtracting stars depending on the home's performance on staffing and quality measures.[1] As table 6 shows, most (87 percent) state veterans homes performed above the median in their state on staffing measures, indicating state veterans homes generally had higher staffing levels per resident compared to other nursing homes. [2] As a result, state veterans home performance on staffing generally increased the number of stars they received for overall quality.

Table 6: Performance of State Veterans Homes on CMS's Star Measures for Overall Quality, Health Inspections, Staffing, and Quality Measures Compared to Other Nursing Homes in Their Respective State, as of January 2022

Category	Above median	Equal to median	Below median
Overall quality	77	18	16
Health inspections	55	18	38
Staffing	94	7	5
Quality measures	42	29	36

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-105167

Note: We chose to base our analysis on how state veteran homes performed relative to the median score of other nursing home in their state because the median splits performance into three groups. For example, if the median score in a state is 3 stars, then homes fall below the median (rated 1-2 stars), at the median (3 stars), or above the median (4-5 stars).

[1]For additional information about how a home's overall and component star ratings are calculated, see CMS, *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide* (Baltimore, Md.: July 2022).

[2]The source for reported staffing hours is the Payroll-Based Journal system. These data are submitted quarterly and are due 45 days after the end of each reporting period. Only data submitted and accepted by the deadline are used by CMS for staffing calculations and in the Five-Star Rating System. Homes then receive scores across several measures, such as the number of registered nurse hours per resident per day. An individual home's performance on these measures is then assessed against the national distribution of the measures.

Appendix VI: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

October 31, 2022

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA NURSING HOME CARE: Opportunities Exist to Enhance Oversight of State Veterans Homes*** (GAO-23-105167).

The enclosure contains technical and general comments and the action plan to address the draft report recommendations. VA appreciates the opportunity to comment on the draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to the
Government Accountability Office (GAO) Draft Report
VA NURSING HOME CARE: Opportunities Exist to Enhance Oversight of States Veteran Home
(GAO-23-105167)

Recommendation 1: The Under Secretary for Health should develop a plan to ensure the data system it is currently developing has the capabilities to aggregate and analyze state veterans home data by multiple units of measurement, including by state and home, and across survey years.

VA Response: Concur in Principle. The Office of Geriatrics & Extended Care, Facility Based Care (GEC-FBC), will explore whether the newly developed Integrated Operational Platform (IOP) has the capabilities to aggregate and analyze State Veterans Homes (SVH) survey data by multiple units of measurement, including by state and home, and across survey years. If the IOP lacks this technical capability, GEC will explore with the Veterans Health Administration's (VHA) Office of Information and Technology what data system options are currently available. If no data system options are currently available, GEC will request the necessary funds through the business forum process for an off-the-shelf product or creation of a custom product for use.

Target Completion Date: September 2025

Recommendation 2: The Under Secretary of Health should implement a process for consistently following up with State Veterans Home that have not implemented their corrective action plans by the agreed upon dates.

VA Response: Concur. GEC-FBC will implement a process to ensure follow up with SVHs that have not implemented their corrective action plans (CAP) by the agreed upon dates. GEC will update the SVH CAP Process Standard Operating Procedure (SOP) to outline this process. GEC will provide this updated SOP to all SVHs through an educational town hall. Additionally, GEC will provide the updated SOP to all Veterans Integrated Service Networks (VISN) and VA medical centers (VAMC). GEC will update its internal survey process tracker to include the latest proposed completion date in the submitted CAP that was approved by the SVH Program Manager. This tracker will then alert SVH Managers to follow up with SVHs that have not submitted evidence of CAP implementation within 1 month of that identified date.

Target Completion Date: March 2023

Enclosure

Department of Veterans Affairs (VA) Response to the
Government Accountability Office (GAO) Draft Report
VA NURSING HOME CARE: Opportunities Exist to Enhance Oversight of States Veteran Home
(GAO-23-105167)

Recommendation 3: The Under Secretary of Health should identify additional enforcement actions that would help ensure State Veterans Home compliance with quality standards and seek legislative authority to implement those actions, as appropriate.

VA Response: Concur. GEC-FBC will develop a process to notify key stakeholders (both state and VA) based on the level/severity of noncompliance with quality standards. The level of noncompliance will determine the enforcement action. GEC will create a legislative proposal for submission. GEC will operationalize these enforcement actions through changes to 38 C.F.R. Part 51 Federal Regulations.

Target Completion Date: December 2025

Recommendation 4: The Under Secretary of Health should ensure GEC's centralization efforts align with VA's policies for national policy management, such as by issuing an interim notice to communicate the oversight changes to all stakeholders and pursuing the expeditious formalization of the new oversight in official directives and regulations.

VA Response: Concur. GEC-FBC will issue an interim notice to VISN Network Directors, VAMC Directors and external stakeholders (to include SVHs) on SVH's modernization efforts, to include forthcoming oversight changes. GEC will revise VHA Directive 1145.01, Survey Requirements for State Veterans Homes, to align with SVHs modernization and ensuing oversight changes once formal rulemaking has been implemented. GEC will operationalize these changes in oversight processes through amendments to 38 C.F.R. Part 51 Federal Regulations.

Target Completion Date: December 2025

Text of Appendix VI: Comments from the Department of Veterans Affairs

October 31, 2022

Ms. Sharon M. Silas Director

Health Care

U.S. Government Accountability Office

441 G Street, NW Washington, DC 20548

Dear Ms. Silas:

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Sincerely,

Tanya J. Bradsher

Chief of Staff

Enclosure

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Target Completion Date: September 2025

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Target Completion Date: March 2023

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GEC will operationalize these enforcement actions through changes to 38 C.F.R. Part 51 Federal Regulations.

Target Completion Date: December 2025

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Target Completion Date: December 2025

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas, (202) 512-7114 or silass@gao.gov

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Erin C. Henderson (Analyst-in-Charge), Rob Dougherty, Topher Hoffmann, Eric Peterson, and Jeffrey Tamburello made key contributions to this report. Also contributing were Vikki Porter, Atiya Siddiqi, Amber Sinclair, Karen Vasquez-Romero, Cathy Hamann Whitmore, Jennifer Whitworth, and Kiley Wilson.

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