# DIGNITY DENIED: THE CASE FOR REFORM AT STATE VETERANS HOMES

## HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON VETERANS' AFFAIRS

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# C O N T E N T S

**TUESDAY, APRIL 29, 2025**

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**TUESDAY, APRIL 29, 2025**

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 2:17 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Taylor, Brownley, Cherfilus-McCormick, Conaway, and Morrison.

Also present: Representative Taylor.

## OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Before we get started, in accordance with committee rule 5E, I ask unanimous consent that Representative Dave Taylor from Ohio be permitted to participate in today's committee hearing. Without objection.

This oversight hearing of the Subcommittee on Health will now come to order. I would like to welcome all members and witnesses to today's hearing. We look forward to a very productive discussion about care for aging veterans.

Every veteran deserves independence and dignity with age. With age however comes challenges. The Baby Boomer generation is getting to an age where long-term care is increasingly needed. More and more veterans are entering a period in life where they are physically and mentally vulnerable or do not live near family members who can assist.

The demands on the U.S. Department of Veterans Affairs (VA) from long-term care will only grow due to the incoming veterans who served during the Vietnam and cold war eras. For some, they have trouble advocating for themselves because of their health needs which can undermine their independence.

This subcommittee works every day to make sure VA health care meets veterans where they are. We know older veterans experience social isolation, or may, chronic pain, mental health challenges, and the VA healthcare must meet our aging veterans' needs. Recent incidents show that there is still work to be done.

I am particularly troubled by veteran suicide later in life. We have talked a lot about suicide in our younger veterans and our veterans who transition out of the service but not much about vet-

erans who commit suicide late in life. Just 2 weeks ago a 77-year-old veteran tragically committed suicide at a VA medical campus.

Sadly, very little research exists about why veterans end their lives at a time when they should be enjoying the fruits of all of their labor.

Through this subcommittee's oversight trips we have heard that older veterans who commit suicide are an invisible population. As a 24-year Army veteran and physician, I refuse to let this issue live in the shadows.

Health care programs through VA are a major contact point where the VA can interact with older veterans. Uniquely, State veterans' homes deal with this population almost exclusively. They are a key means by which we can support older veterans on a daily basis.

State veterans' homes are long-term care facilities for veterans and often for their spouses. They are state-run but receives substantial amounts of funding from the VA.

When VA supports State veterans' homes it is also supporting a compilation of smaller programs. VA gives funds for State veterans' homes to support programs like resident care, domiciliary care, and adult daycare.

In addition, VA provides grants for facility construction through a matching program with states. The VA also provides grants for nursing retention at State veterans' homes. These programs help veterans flourish later in life.

Are we sure that the VA is helping State veterans' homes meet their full potential? This oversight hearing is meant to answer this question. I know that most homes throughout the country give the quality of care that veterans in need deserve but there are notable outliers.

In 2020, at a State veterans' home in Holyoke, Massachusetts, over 70 veterans died with COVID–19 during an outbreak during the pandemic. Many more suffered infections. An independent investigation revealed that this horrific tragedy was preventable.

Additionally, Government Accountability Office (GAO) reported that the total number of demerits for failing requirements in the annual VA audit increased from 2019 to 2021.

The good news is that these are exceptions rather than the rule, but what can we do to make sure all homes offer the standard of care veterans deserve? I believe the VA can help State veterans' homes succeed.

We know that the VA has money. We give it to them every year. Again, the VA disburses a substantial amount of funding to support State veterans' homes through reimbursements and grants. We must make sure the VA allocates these funds to the right resources.

That is why I have introduced a bill to provide veterans with more access to essential medications. My bill would reimburse State veterans' homes for medication cost.

Currently, the VA does not pay State veterans' homes for high cost medications for severely disabled veterans, yet they are often revolutionary cancer drugs that can help significantly lengthen the veteran's life and quality of life. These medications are covered outside of the facility rather than through the State veterans' homes.

I have said it before, I will say it again. It is critical to expand the network veterans can use to access lifesaving medications. I also know that construction grants come with strings attached that may not make sense for the veteran or the State veterans' home supporting them. I look forward to discussing this and more with the witnesses before us today.

Older veterans deserve quality long-term care. We owe it to them to put them at the forefront of our conversation about veteran healthcare.

I now yield to Ranking Member Brownley for any opening remarks she may have.

**OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER**

Ms. BROWNLEY. Thank, you Madam Chair. Overall, an estimated 80 percent of veterans will need long-term services and supports at some point during their lifetime. The overwhelming majority of aging adults, including veterans, would prefer to age in place in their homes rather than nursing homes.

With the recent enactment of the Elizabeth Dole Act, Congress bolstered VA's authority to offer home and community-based services for aging and disabled veterans. We are eager for VA to implement this law as soon as possible.

However, even with this expansion of VA's non-institutional long-term care programs, not every veteran will have enough support from family members or other caregivers to enable them to safely age at home. For that reason there will always be a need for nursing homes.

State veterans' homes, which are owned and operated by the states with Federal investments in the form of construction grants and per diem payments, are the largest provider of institutional long-term care for veterans. Collectively, they serve more than 43 percent of the veterans receiving VA-funded nursing home care on any given day in 2023.

VA-operated community living centers served about 20 percent and VA purchased care from community nursing homes through the remaining third of veterans.

Despite serving the majority of veterans for whom VA purchases nursing home care, State veteran homes receive only about 18 percent of VA's total payments for institutional long-term care. VA's basic per diem for State veteran homes now covers less than 30 percent of the actual cost of care and as little as 20 percent in some states with higher costs of living.

State veteran homes make up the balance of their costs through other funding sources including State support, Medicare and Medicaid, and the veterans themselves who share in the cost.

This week and next, 11 other House committees will mark up budget reconciliation legislation ramming through draconian cuts to Federal programs that serve the most vulnerable among us, all to fund tax cuts for the very wealthy.

The House Energy and Commerce Committee has been instructed to cut $880 billion over 10 years and nearly all of those cuts are expected to come from Medicaid, which funds long-term care for more than 60 percent of nursing home residents.

With many community nursing homes already teetering on the brink of financial insolvency, these Republican budget cuts would put them at greater risk of closures.

Medicaid also funds many home and community-based services enabling aging and disabled people, including veterans, to avoid institutional settings and care. Should these Medicaid cuts come to pass, veterans will become more reliant on VA and State veteran homes for long-term services and supports.

I certainly hope both the administration and the states will be factoring this into their budget proposals in the coming years.

I also must say I am perplexed by the title of today's hearing. For many veterans the sense of community and culturally competent care that has historically been provided by State veteran homes allows them to retain their dignity in their later years. State veteran homes were established by the states and are supported by VA as a way to honor our Nation's promises to veterans through the end of their lives.

If anything, I would argue that cutting safety net programs on which many veterans rely, like Medicaid, will ultimately deny them the dignity they deserve. This subcommittee last held an oversight hearing dedicated to State veteran homes almost 5 years ago in the early months of the COVID–19 pandemic. At the time, heartbreaking tragedies were unfolding in nursing homes across the country, including at several State veteran homes where staffing shortages, outdated physical infrastructure, and poor infection control practices led to the rapid spread of the virus.

The pandemic quickly exposed the critical importance of strong oversight and ongoing monitoring of the quality of care and patient safety at nursing homes. During the pandemic, Congress acted to address gaps in State veteran home oversight and provided $1 billion in funding to support grants for State veteran homes' instruction and operational needs.

Unlike the slash and burn budget reconciliation process House Republicans are undertaking, we used the budget reconciliation process in 2021 to infuse much-needed funding for State veteran homes and other critical programs on which Americans rely.

We also improved VA's oversight of State veterans' homes under the Cleland-Dole Act, which was enacted in 2022. VA is now required to document all deficiencies identified during State veteran home inspections, even ones that are corrected on the spot.

In addition, this law required VA to publish the results of State veteran home inspections and corrective action plans on its public-facing website so that veterans and their loved ones can make more informed choices about where to receive nursing home care.

I look forward to hearing more from our witnesses today about the progress that has been made and the challenges that still remain in State veteran home operations and oversight.

With that, Madam Chairman, I yield back.

Ms. MILLER-MEEKS. [Audio malfunction.]

## STATEMENT OF SCOTTE HARTRONFT

Mr. HARTRONFT. Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee. My name is Dr. Scotte Hartronft, and I am the Ex-

ecutive Director of the Office of Geriatrics and Extended Care at the Department of Veterans Affairs. I am honored to discuss the strategic approach VA employs, which results in high-quality health care outcomes and support for the Nation's heroes at State Veterans Homes (SVH). SVHs are owned, operated, and managed by the states. VA's role as it relates to SVHs is as a support to ensure Veterans receive the high-quality care which meets the Department's standards, through annual certification and recognition surveys, Medical Sharing Agreements, and grants to construct, renovate, or repair State owned facilities. Currently, the Department supports 172 SVHs, which administer a combined 166 Nursing Home Programs, 47 Domiciliary Care Programs, and 3 Adult Day Health Care Programs. To participate in the SVH program and its benefits, VA must formally recognize a care facility as an SVH through the certification process and a recognition survey. Along with compliance with VA standards, a recognition survey requires adherence to all applicable Federal, State, and local laws including the relevant professional standards for VA purposes to recognize the home as an SVH. After formal recognition, VA conducts at least one unannounced annual survey at each facility to ensure compliance with VA standards. The VA surveys cover 200 clinical standards, fire and life safety standards, administrative standards, and fiscal standards. Page 1 of 2 Many of the standards are based on the Centers for Medicare and Medicaid Services (CMS) nursing home standards but others are VA and SVH unique. Any areas of non-compliance identified on surveys are addressed through corrective action plans in collaboration with the Veterans Health Administration (VHA) survey team. During the corrective action plan follow-up period an ad-hoc for cause full survey can be completed if felt necessary. Compliance with VA regulations under 38 C.F.R. part 51 and VA's survey and certification process is required for SVHs that provide nursing home care, domiciliary care, or adult day health care to remain eligible to receive per diem payments or participate in the State Home Construction Grant Program.

The VA survey process mirrors the Centers for Medicare and Medicaid Services for long-term services and long-term care facilities. VA offers support to State veterans' homes by permitting recognized State veterans' homes to enter into medical sharing agreements with our local VA medical centers to secure additional clinical services, more secure discounted pharmaceutical prices.

As of February 2025, State veterans' home nursing homes that are CMS-certified scored on average higher on the overall star rating for the national CMS nursing home average.

To maintain State veterans' home recognition, VHA may also provide funds to ensure adequate levels of nursing staffing. In Fiscal Year 2025, VA approved $4.7 million for the 17 states and 47 State veterans' homes that applied for Federal grants to support programs to hire and retain nursing staff.

The State Home Construction Program is a partnership between VA and the states to construct, renovate, or repair state-owned and operated nursing homes, domiciliary, and/or adult day health care facilities.

VA provides reimbursement up to 55 percent of allowable costs to states for the construction and renovation of State veterans'

homes. The number of awards provided each year depends on the number of projects, their costs, and the amount of appropriation received for the fiscal year. VA as well is responsible for determining the priority for the funding for facility improvement, which may include bed replacement, mold removal, and repairs to structural hazards to State veterans' homes to maintain their recognized status.

In conclusion, VA remains steadfast in its dedication to continuous improvement in the oversight of State veterans' home. We appreciate the oversight from the committee and look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF SCOTTE HARTRONFT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Well, thank you. I would just like to remind our witnesses to speak more directly into the microphone. Either move it closer to them or move closer to the microphone.

Ms. Silas, you are now recognized for 5 minutes to present your testimony.

## STATEMENT OF SHARON SILAS

Ms. SILAS. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, I am pleased to be here today to discuss our prior work on State veterans' homes. My testimony today describes the oversight structure of State veterans' homes and opportunities to improve VA's oversight.

VA projects that the demand for long-term care will continue to increase, driven in part by growing numbers of aging veterans and veterans with service-connected disabilities.

As of Fiscal Year 2023, there will be about 15,000 veterans living and being cared for in State veterans' homes at a cost of $1.5 billion.

In our November 2022 report, we reported that there were 153 State veterans' homes providing nursing home care in the United States. These homes are an important resource for housing and care for some of our most vulnerable aging veterans.

State veterans' homes are owned and operated by the states, however, VA provides per diem payments for eligible veterans to receive care in these homes, and as of Fiscal Year 2023 the average daily cost per veteran per day was $265.

There are three entities that may have a role in overseeing State veterans' homes: the VA; the Centers for Medicare and Medicaid Services, or CMS; and the states.

First, VA is the only Federal agency that has oversight responsibilities for all State veterans' homes. While VA does not exercise any supervision or control over the administration, personnel, or maintenance of the homes, VA does provide oversight through annual inspections.

Through these inspections, homes are assessed against quality standards, cited deficiencies if they do not meet these standards, and then they are required to develop a corrective action plan to address the deficiencies.

CMS also provides oversight of those State veterans' homes that has received Medicare or Medicaid. CMS certifies homes in order for them to receive funding.

Once certified, CMS will conduct inspections about every 15 months to determine whether the home is meeting quality standards. We found that nearly 76 percent of the 153 homes in our study were also inspected by CMS.

Some states also provide state-specific oversight of State veterans' homes. For example, these states may have state-specific regulations for nursing home quality or they are able to take enforcement actions at the home.

As part of our review, we found that 43 states conducted their own oversight in addition to oversight conducted by VA and CMS, but the remaining seven states where there was no State oversight, five states' State veterans' homes received oversight from CMS and VA and two State homes only received oversight from the VA.

In our report we made four recommendations for VA to improve its oversight of State veterans' homes and one recommendation remains open. During our review we found that VA's only enforcement action to compel homes to address deficiencies was to withhold per diem payments for veterans, a severe action that could ultimately impact the veteran's care.

Officials expressed reluctance to use the enforcement tool unless under extreme circumstances. In fact, at the time of our review, VA officials could not recall ever withholding a State veterans' home's per diem.

Further, we found in our November 2022 review of 153 State veterans' homes there were a total of 756 deficiencies. 40 percent of State veteran homes were cited for the same deficiency in 2019 and 2021. 21 percent of the deficiencies had corrective action plans that were past their due date.

Moreover, in our review, we cite an example of a State administrator that noted they were more concerned with CMS' inspections because of the civil penalties.

VA could benefit from having a range of enforcement actions similar to CMS that would provide a more effective tool to motivate State veterans' homes to comply with standards. CMS has a range of enforcement actions, including civil penalties that are aligned with the scope and severity of the deficiency. Having a similar approach to help VA more effectively target penalties and better compel State veterans' homes to come into compliance with quality standards.

During our review, VA told us that they were considering a legislative proposal to Congress for authority to impose fines or withhold a percentage of the per diem payment to address noncompliance with quality standards. We believe this to be a good step to creating a range of enforcement actions that would be effective.

Subsequently, GAO recommended VA identify additional enforcement actions that would help ensure State veterans' homes' compliance with quality standards and seek legislative authority to implement those actions. Although VA concurred with our recommendation, they have not identified additional enforcement actions. Instead, VA has responded by developing a new enforcement plan that strengthens internal timelines and increases the follow up with homes that have deficiencies.

While these are good steps to strengthen oversight of State veterans' homes, they are not necessarily actions that will compel the

homes to comply with quality standards. Our veterans residing and receiving care in State veterans' homes are our most vulnerable. Having a range of enforcement options that, for example, are scaled to the scope and severity of deficiencies similar to CMS' range of enforcement actions would provide VA with more effective enforcement and better ensure that State veterans' homes are providing the high quality care veterans and their families deserve.

That concludes my statement and I am happy to take any questions.

[THE PREPARED STATEMENT OF SHARON SILAS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Ms. Silas. As is my typical practice, I will reserve my time for questions until all of the members have had a chance to ask their questions.

I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair.

Dr. Hartronft, it is nice to see you again. My first question to you, and I would appreciate a brief answer, is if these Medicaid cuts happen, if there is a significant cut to Medicaid, have you done any kind of analysis on the extent to which this would increase veterans' reliance on the VA for long-term services and supports?

Mr. HARTRONFT. Thank you for that question. We have not heard of any specific amount so we have not had any discussions, but the VA, as usual, can be flexible with any changes in the market based on expanding our use of other contractors in homes and other facilities.

Ms. BROWNLEY. You do agree that if there were significant cuts to Medicaid it would have an impact on, you know, veteran services and longer term care such as state-owned nursing homes?

Mr. HARTRONFT. Most of any potential impacts I would have to defer to CMS but, obviously, we would respond if we think that adequate changes are necessary.

Ms. BROWNLEY. Okay. Let me ask you in terms of the GAO's recommendations, there are 20, 22 recommendations to seek legislative authority for a broader range of enforcement actions. According to the GAO as of 2025, VA is no longer interested in pursuing additional legislative authority.

You were the executive director of the geriatrics and extended care program when GAO made this recommendation, so what changed between 2022 when you concurred with it and now, aside from the obvious change in Presidential administration, did new leadership within the VA directives change?

Mr. HARTRONFT. What I can explain is as to in 2022 we were in the process of a modernization effort which we centralized all the surveys within VA central office instead of each local VA doing that. What we did was we also added what we call an escalation plan that puts, based on the number of survey findings and severity in the categories of one through four, and that prescribes a frequency of oversight.

What we have done is since February we have noticed that the outcomes has been positive in the sense that 100 percent of our corrective action plans are now on time and they are meeting their compliance. We also addressed in our corrective action escalation

plan what we need to do. If we were to seek any penalty we would work with the Veterans Integrated Service Network (VISN), the local VA, and determine within what is in our current Code of Federal Regulations (CFR) and regs to propose any penalties.

Ms. BROWNLEY. You did not feel with this reorganization that you are speaking of, did not feel the need for any kind of financial as in a fine or percentage of the per diem as something that would leverage better accountability?

Mr. HARTRONFT. Well, based on external feedback we have been able to restart discussions internally and we are, kind of, in the discussion and concurrence phase, so we have not ruled that out. We are just now going back to that.

Now that we have something in place that we did not have before and we have shown good compliance with it we now are going back to see and discuss do we think there is any other appropriate actions that we might need to have in place if we would have problems.

Ms. BROWNLEY. Ms. Silas, do you, kind of, agree with that assessment?

Ms. SILAS. Yes. I mean, we believe that the steps that the VA has taken to increase their oversight was really helpful. They strengthened their timelines. They were doing more follow up with the homes and that is really gone a long way I think to improve oversight.

We still think that there needs to be some sort of tools that have some teeth to them to make sure that they can hold the State veterans' homes accountable. I think it is also really important that it is a range and so that it is very similar to CMS, as I mentioned in my statement, where it is a range that is aligned with the scope and severity of the deficiency and that way you can, kind of, right-size the tool to ensure there is accountability in the home.

Ms. BROWNLEY. Great. Dr. Hartronft, so the next panel there is going to be testimony from the State Veteran Home Association expressing some concern that the VA medical centers are not really working with the residents in the State home to ensure that they receive specialty care, including mental health and psychiatric care, that this has been, sort of, an ongoing concern. Can you speak to that?

Mr. HARTRONFT. Yes, ma'am. It is a continuous improvement that we work with the association because there we are paying part of our per diem does cover basic primary care, and in nursing homes it does count for normal primary care-related mental health levels working with depression, things like anxiety. Really just us clarifying the difference between primary care level that we are paying per diem versus specialty care, and that is why we have local liaisons that work with the State veterans' home to try and make sure they can afford the medicine and specialty care that is above the ability of the State home.

Ms. BROWNLEY. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley.

The chair now recognizes Representative Cherfilus-McCormick for 5 minutes for any questions she may have.

Ms. CHERFILUS-MCCORMICK. Thank you so much. In typical fashion we are hearing the same old tired playbook from our colleagues across the aisle, identify a program that serves the most vulnerable and put the program under a microscope, pick out any perceived flaws, ignore the program's success, defund that program, and push veterans into the private sector.

Today's strategies are the State veterans' homes, which provide almost half of all of our Federal long-term care support services to our Nation's veterans. This critical lifeline is one of the most lean and effective programs in all of VA.

Per diem payments to these homes for skilled nursing care are one-third less than the cost of private sector nursing homes and almost 90 percent less than the VA's community living centers. State veterans' homes only have the capacity to serve 30,000 veterans, well short of the 8.4 million veterans who are 65 and older.

Instead of cutting funding for these programs, we should be actively pursuing solutions that expand the capacity of these facilities to treat more veterans and equip VA with the staff needed to conduct effective oversight.

Dr. Hartronft, as the executive director of the Office of Geriatrics and Extended Care at the VHA, you are responsible for ensuring VA's veterans' homes are safe and provide quality, long-term care to our veterans. In your view, does your office currently have enough staff to fulfill this core mission?

Mr. HARTRONFT. Currently we are adequately staffed.

Ms. CHERFILUS-MCCORMICK. What is your plan to move these deficiencies that were pointed out that have been consistent and pervasive?

Mr. HARTRONFT. Okay. Most of them have been fully addressed with oversight. Again, what we did before was each local VA was responsible for the surveys and the follow up, whereas now we have centralized it where we have a consistent, assigned staff that they go, that work and oversee the same nursing homes. Then that way they can follow them all the way through the survey through all the steps and the corrective action plan and then get them from provisional to full certification.

Ms. CHERFILUS-MCCORMICK. Now, your statement sounds the contradictory to what Ms. Silas has stated with the consistent deficiencies. Is that correct or is there—am I missing something, Ms. Silas?

Mr. HARTRONFT. Then I guess I must have heard the question wrong, my apologies. Can I—could you——

Ms. CHERFILUS-MCCORMICK. The deficiencies. When we talked about the deficiencies, well, when Ms. Silas spoke about the deficiencies and the consistency of those deficiencies and how there seems to be more direction in toughening up the standards and not really curing the deficiencies. I wanted to know if you had enough staff and if so, if not, how are you actually planning on meeting and reversing course on these deficiencies?

Mr. HARTRONFT. Okay, thank you, ma'am. Just as an overall industry, in the CMS whenever they survey homes the number of survey findings in the community, as well as the State veterans' home deficiencies over time, as well as the fair review of those deficiencies. We are a reflection of the larger industry.

What has changed over the time since the last time we really had the full review from the GAO is our centralization of the process. They may have an increased number of deficiencies, but our staff are working with them from the day of the survey until the completion of the corrective action plan and getting evidence of compliance. They are getting evidence of closure much more and to the point where it is higher quality and much improved over time.

Ms. CHERFILUS-MCCORMICK. Now, I have listened and spoke to many State homes and they have all complained about the same issues when it comes to funding and not having enough staff, not even being reimbursed for a certain amounts to provide food, especially at this time when there is inflation.

Ms. Silas, I would like to hear from you what your view is on the deficiencies and do you feel like cutting funds would actually help them to cure or would it actually exacerbate the issues you are finding?

Ms. SILAS. I do not think I can speak directly to the cuts because we have not conducted a review looking specifically at those, but I will say that my testimony, the report that we did that was back in 2022, we had four recommendations we made. Some of the things that Dr. Hartronft was talking about in terms of the centralization of the Geriatrics and Extended Care Office and the oversight——

Ms. CHERFILUS-MCCORMICK. Well, I do not mean to cut you off because my time is running out——

Ms. SILAS. Sure, Okay.

Ms. CHERFILUS-MCCORMICK [continuing]. but I just wanted to add this fact to you, so as you are going on. They are looking to cut 72,000. With that fact being there you can go ahead and continue.

Ms. SILAS. Sure. I do know that the oversight for the State veterans' homes was very decentralized to the VA medical facilities and so there was, I guess, over 100 staff that were trying to monitor the State veterans' homes. With the centralization I think there is four or five staff now that are focused on monitoring a set of homes within the region.

They are able to, as Dr. Hartronft was saying, being able to track the corrective action plans and make sure that there is closure and that the deficiencies are being addressed.

Ms. CHERFILUS-MCCORMICK. Thank you.

I yield back.

Ms. MILLER-MEEKS. Thank you very much.

The chair now recognizes Dr. Conaway for 5 minutes for any questions he may have.

Mr. CONWAY. Thank you. I would start by just providing some background, a New Jersey situation. Last year the former Attorney General Merrick Garland, filed a complaint in the U.S. District Court for New Jersey against New Jersey Veterans Memorial Homes at Menlo Park and Paramus.

The two veterans' homes landed in the national spotlight for reports of a significant number of deaths that occurred during the pandemic and called for more oversight and investigation. Well, as a result of the action by the district court, families of 119 residents of those facilities entered into a settlement in which each family re-

ceived an average of $455,000 and a total settlement of $53 million. The State was responsible for paying 60 percent of that.

Now, as the outbreak was raging, did the VA get into veterans' homes, not only in New Jersey but across the country, to respond to the deaths that were occurring and the other, you know, related illnesses that were occurring in the homes? That is, did somebody from the VA go to these various homes to enter—to conduct a review of operations during the pandemic in those homes?

Mr. HARTRONFT. Thank you, sir, for that question. The local VA's were in constant contact with their State veterans' homes, but obviously since the State owns, operates, and manages them there was only so much we can do outside of our oversight. It was individualized and different for each home, so if there is any specific homes we can go back and ask and find out more details what the local VA actually did with each facility, whether it was in-person, whether it was a telephone consult, or if they provided staff or resources or other things.

Mr. CONWAY. There were in-person visits to the homes to try to understand if there were attempts to separate the ill patients from patients that were not ill or to review any recent deaths in those homes and whether or not they had adequate staffing in the homes to make sure that the residents of those homes were safe in light of the pandemic?

Mr. HARTRONFT. It varied from home to home based on what the State facility was working and communicating with the local VA, so it varied from site to site, but I do not have the details from each specific VA, data from each specific State home, but I can take that for the record if you would like to know more about any specific home.

Mr. CONWAY. Ms. Silas tells us that the VA, and perhaps you mentioned it and I am sorry if I missed it, that the VA does not have the kind of authorities that, as I heard it, they ought to have to ensure compliance with outcome standards, with standards of care in the home.

Do you agree with that statement? This is to the doctor to provide me—you made the statement, Ms. Silas, but I wonder if the doc agrees with what you said?

Mr. HARTRONFT. Yes. We are working within our current limitations with the CMR and USC, so that is why we put the escalation in place because that could be done more immediately while we do have now internal discussions as to what we need to do above that. We are in the concurrency discussion phase, but we, again, I would point out that so far the outcome from our new plan has been successful and there not being anybody out of timelines for any corrective action plans not being addressed.

Mr. CONWAY. Now, well, Ms. Silas, do you want to—well, let me get to this. Do you feel that if you do not have the appropriate authorities, if you will, or actions beyond reviewing a corrective action plan, which are very important, of course, what do you do without legislation? What can you do to really improve that without legislation to give you more authority and to ensure compliance with what one would consider to be appropriate nursing home standards?

Ms. SILAS. Sure. Without having some of those authorities, I mean, what we were really looking for is the ability to apply civil penalties or to take part—do a partial per diem payment to stop back. If you do not have the authority to take those types of actions you are going to have to get faith in word and do changes internally, which I think the VA has done where they have strengthened their timeline. They have done more follow up with the homes.

They also have an option to pause admissions to the State veterans' homes, even though veterans can still be admitted to the State veterans' homes. They do not have to be referred from the VA itself.

They have taken some actions but they are all very internal and they are all around the processes and what we really want to see is to see something that has a real, again, I will say teeth again and a real penalty so that there is more accountability for the State veterans' homes.

Then having some of those tools and especially providing a range they can, kind of, right-size the accountability to the State veterans' homes.

Mr. CONWAY. Thank you.

Thank you, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Dr. Conaway.

The chair now recognizes Representative Taylor for 5 minutes for any questions he may have.

Mr. TAYLOR. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley for holding this hearing today and allowing me to participate.

Thank you to our witnesses also for your insight and testimony. My home State of Ohio has two State veterans' homes with one being located in my district in Georgetown, so I appreciate the opportunity to engage on this important issue.

Dr. Hartronft, I understand there is a large backlog of State veterans' homes awaiting Federal construction grant funding. These projects that have already secured their State share of the funding and are ready to go as soon as they receive their matching Federal grant. However, at current funding levels some projects may have to wait 5 to 10 years to receive their matching Federal dollars.

Can you describe some of the projects and some of the conditions that veteran residents may have to face while these homes await Federal funding?

Mr. HARTRONFT. Thank you, sir. I do not have the list of the actual approval and projects in front of me, but what we do is with the funds that we do have each year it is a dynamic for anything necessary from 1 year to the next if it is not covered in the funding zone window it is moved to the next year. They may change in the listing order based on if there is a new application that has a higher priority level based on necessity or some other issues.

We do carry them over and then we continue to construct based on the length and——

Mr. TAYLOR. As the veteran population ages and as the backlog of State veteran home construction projects continues to grow, how does the VA plan to alleviate the backlog?

Mr. HARTRONFT. The good news is that we already have several facilities that we know are coming online within the next year, or the next 2 years, so there are many projects that are going through, which really working with the states to identify where those best locations are.

Again, we do not determine where the states place them or how big they or the services. We largely respond to the applications that we receive title work for the State to see how we can best make the situation the best possible.

Mr. TAYLOR. You have new projects coming online while these, I think there are in excess of 80 tier one projects that have their State funding lined up waiting for Federal funding. There is no plan to do more than what has usually been done to chisel down that list?

Mr. HARTRONFT. We received around, I think it was during COVID, we received a larger financial appropriation and we were able to go further down the list. We were able to also help those facilities during that time to renovate so that they could have better ventilation systems, largely focused toward COVID. Many of them benefited from us having that larger thing to where they could actually do Heating, Ventilation, and Air Conditioning (HVAC) changes and other benefits.

Mr. TAYLOR. Thank you, Doctor.

To me it appears this is a question of priorities and I think now is a great time for Congress to have this conversation as we consider where our Federal Government spends our tax dollars we must always keep veterans at the forefront as we root out waste, fraud, and abuse from several different programs within the Federal bureaucracy. We would recognize State veteran homes from across the country are being left behind. It is unacceptable to me that our government would send tens of billions of dollars overseas while leaving veterans to wait years for much-needed modernizations at State veterans' homes, including the Georgetown home I represent.

That is why I introduced the Veterans First Act, which would take a small fraction of the identified wasteful spending and repurpose it to clear up the existing backlog of State veterans' home construction grants.

For President Trump and the White House the days of spending money on things like electric cars in Vietnam and Diversity, Equity, and Inclusion (DEI) projects in Serbia are over. To that end, I will keep working to get our Nation's spending priorities straightened out and the veterans are at the top of the list.

Once again, I thank the committee for the opportunity to speak today. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Taylor.

I now recognize and yield myself 5 minutes to ask questions. First and foremost, thank you very much for being here. State veterans' homes being State run do they also get oversight or investigations, if you will, from a state's Department of Inspections and Appeals that oversees nursing homes within the states that are not a veterans' home?

Ms. Silas or Dr. Hartronft.

Ms. SILAS. Sure. As we reported in our report, there were a total of seven homes that were not getting State oversight. Five of them were getting oversight by CMS and then there were two states that will have no oversight except for the oversight from VA.

Ms. MILLER-MEEKS. The majority then would have oversight at the State, as well as the VA?

Ms. SILAS. Yes.

Ms. MILLER-MEEKS. Thank you for that.

Dr. Hartronft, our subcommittee has learned that older veterans are considered an invisible population when it comes to suicide prevention. What has the VA observed about older veteran suicide and what mental health care service is available at the VA for older veterans and help lower the incidence of suicide deaths? I know you mentioned this in your remarks.

Mr. HARTRONFT. Thank you, ma'am. There is a lot of layers that we do at the State veterans' homes and we really respond to what education they request because of what they are seeing in their population at the time. A lot of our mental health training and education has been over disruptive and disturbing behaviors, obviously, as well as falls, but we have been working with the Office of Mental Health and Suicide Prevention and they are actually in the active process of planning new educational interventions at the State homes and others when it comes to suicide prevention, especially in the elderly population, which is actually psychiatry.

Ms. MILLER-MEEKS. Could is also being complicated by the incidence or, excuse me, prevalence of Alzheimer's or dementia as one ages?

Mr. HARTRONFT. Yes and no. From the geriatric perspective, obviously, there is dementia and other aspects but also, especially in elderly men after they become recent widows, there is those significant changes in life when they do have that increase across all populations, the veteran and non-veteran based on age. That is one reason why we are working with the Office of Mental Health to get geriatric psychiatry to get those levels of education and recognition because they can be very subtle in the older population.

Ms. MILLER-MEEKS. I would also like to commend you on the response by the modernization, the changing in your processes, the going from decentralization to some centralization which has helped to clear up a lot of the deficiencies and demerits within the system, so I am just going to—there has been a little bit of criticism toward you for that but let me commend you on being able to do as much as you have by looking at the process itself and to see how you can change behavior through that mechanism.

Can a State veterans' home that receives citations for deficiency in the annual VA audit still get funding on the same terms as a home that receives no deficiencies?

Mr. HARTRONFT. In the overall nursing home industry it is rare that no one gets no deficiencies, but just, kind of, showing that single digits usually. Because there is over 200 standards at the VA we call it the CMS standards plus fiscal with the administration, we do a ton of standards.

It would be very rare that you do not have at least one, no matter being a very good facility. There is always some policy or something that might get you somewhere, but overall we have seen

where we work with them very closely and really just making sure that things get cleared up and they get the support they need.

We have literally had some State veterans' homes where the local VA sent staff to provide direct education just in time and others to really make sure that we are getting—we are really wanting the outcomes. The outcome is really to make sure that the veteran gets better care, so the local VAs have invested a lot in their local VA State veterans' homes.

Ms. MILLER-MEEKS. Would more enforcement measures create more opportunity for correction?

Mr. HARTRONFT. At this time based on the outcomes we are seeing with our current escalation plan, which is our outcome is to get these compliant and we have been successful. Again, as I said, we have been taking some external feedback to the point where that we are discussing are there next steps? That will obviously take longer in time, but we really wanted to focus what could we do more immediately within our parameters, knowing that some of the other measures may take a little longer going through other processes.

Ms. MILLER-MEEKS. Again, I commend you for what you have been able to achieve thus far.

I had a question for Ms. Silas but, Ms. Silas, I will submit it for the record since my time is running out.

On behalf of the subcommittee I want to thank you all for your testimony and for joining us today. You are now excused and we will wait a moment as the second panel comes to the witness table. Thank you so much.

I would now like to introduce the panel two witnesses. Testifying before us today we have Mr. Ed Harries, president of the National Association of State Veterans' homes. Mr. Harries, if I have mispronounced your name please feel free to correct me. The Honorable Charlton J. Meginley, colonel, retired U.S. Air Force, secretary of the Louisiana Department of Veterans Affairs (LDVA).

Mr. Harries, you are now recognized for 5 minutes to deliver your opening statement.

## STATEMENT OF ED HARRIES

Mr. HARRIES. Chairwoman Miller-Meeks and Ranking Member Brownley, as president of National Association of State Veterans' Homes (NASVH) thank you for inviting me to testify today.

State homes provide about half of all VA-supported skilled nursing care for veterans, yet we consume only 18 percent of the VA's total budget for this care. According to the VA, the calculated institutional per diem for State homes is $262 compared to $424 for private community homes, and $1,971 for VA Community Living Care (CLC).

According to CMS data, the veterans' homes are safer, have a higher quality rating, and receive fewer substantiated complaints and citations compared to community nursing homes. Approximately 70 percent of the State homes are rated as four or five star facilities compared to just 35 percent of the community homes.

State homes also had 70 percent fewer substantiated complaints and half the number of infection control citations. Community

homes are primarily overseen by CMS while State homes have significant oversight from VA, CMS, and our State government.

All homes receive annual VA inspections and 75 percent are also inspected by CMS. 85 percent are subject to either annual or for cause infections by their states.

Madam Chairwoman, while oversight is a necessary component of any well-run organization, it must be balanced against the dangers of overregulation.

Nursing home administrators spend an estimated 20 percent to 30 percent of their time on regulatory compliance and reporting, diverting focus from resident care and staff management.

Overregulation creates a high pressure environment for staff. Studies from the Journal of Nursing Regulation linked high levels of regulatory burden to increased stress among frontline staff and administrators alike.

Overly burdensome regulations can also stifle innovation. The Rand Report noted that facilities hesitant to adopt telehealth, personalized dementia interventions, or adaptive care models often cited fear of regulatory noncompliance as a primary barrier.

While good governance of any organization must include a through and effective oversight, overregulation can undercut its efficacy.

Madam Chairwoman, NASVH has several recommendations to strengthen and expand services for aging veterans at State veterans' homes. We strongly support the Providing Veterans Essential Medications Act, and we want to thank you and Congressman Pappas for introducing this legislation to address the problem of high cost medications.

We were both surprised and disappointed that the VA testified in opposition to your bill. VA officials were aware of the problem and have told NASVH on multiple occasions in recent years that they were interested in solving it.

The technical concerns raised by the VA could all be easily overcome with clarifications and additional legislative language. We stand ready to work with you and your committee to perfect this legislation.

Another problems State veterans' homes must overcome is the VA's failure to cover the cost of specialty care. Although VA is required by law to pay for specialty care, in practice the VA is regularly refusing to do so, particularly for psychiatric care.

Madam Chairwoman, many State veterans' home face continuing and significant financial challenges due to the COVID pandemic. We are still recovering. To help address this problem, NASVH supports an increase in the basic per diem rates and calls on Congress to appropriate at least $650 million to put toward ending construction projects.

Finally, I would like to discuss how the veterans' homes may help improve mental health support for aging veterans. Public Law 117 through 28 require the VA to create a geriatric psychiatry pilot program in the State veterans' homes. Instead, the VA implemented only a limited expansion telemedicine mental health services.

NASVH believes that the homes could play a larger role in addressing the mental health needs of our aging veterans. We would

like to work with you to develop a new pilot program to do exactly that.

Research has shown that many of the supports that State veterans' homes provide to its aging veterans require protective factors for veterans in crisis and at risk for suicide. Expanding the scope of the long-term care services offered by veterans' homes could play a small but meaningful part in the VA's suicide prevention efforts.

That concludes my statement, and I would be pleased to answer any questions you or any members may have.

[THE PREPARED STATEMENT OF ED HARRIES APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Harries.

Secretary Meginley, you are now recognized for 5 minutes to deliver your opening statement.

**STATEMENT OF CHARLTON MEGINLEY**

Mr. MEGINLEY. Chairwoman Miller-Meeks, Ranking Member Brownley, distinguished members of the House Veterans Affairs Committee (HVAC), on behalf of Governor Jeff Landry thank you for providing us the opportunity to address the critical topic of long-term care for our veterans, specifically in Louisiana's veterans' homes, which I will give you a little bit of information about.

While I cannot speak for the operations in other states, I assure you that Louisiana we have the requisite leadership, oversight, and a highly competent and dedicated staff to ensure that our veterans receive high quality, safe patient care and are always treated with the dignity they have earned and deserved.

Our five veterans' homes in Louisiana are situated and placed across the State. They are sanctuaries for those who have sacrificed greatly for our Nation. These facilities provide more than shelter and medical care. They offer a community where veterans are honored, respected, and cared for with deep compassion.

Our staff, the nurses, administrators, aides, social workers, therapists, and support personnel are the heart of this sacred mission. They take the time to understand each veteran's needs, stories, and preferences and, in turn, build meaningful connections.

Whether assisting with daily activities or maybe medical care or simply listening, these professionals create an environment of dignity and respect. Their work reflects a profound commitment to preserving each veteran's worth through connection, purpose, and recognition.

Now, contrary to the 2022 GAO report, we believe our veterans' homes operate under significant oversight to ensure the highest standards are maintained.

Federal and State agencies, including the Department of Veterans Affairs, Centers for Medicare and Medicaid Services via Louisiana Department of Health, Louisiana legislative auditors, Louisiana Office of Risk Management, Louisiana civil service, along with our own DVA internal auditors and our own DVA compliance team conducts regular inspections to evaluate everything from medical care quality to facility safety.

Compliance with these rigorous standards is mandatory. This oversight is complemented by internal quality assurance programs

and an ongoing policy revision and staff training that prioritize quality care and resident rights, patient safety, and well-being.

Any concerns raised by any resident or their family members are addressed through formal grievance processes, which ensures accountability at every level. Under our leadership, our clinical teams have driven significant improvements in care quality.

VA survey deficiencies decreased by 36 percent from 53 in 2023 to 34 in 2024, but the 34 does not really tell the whole story. Further breakdown of these 34 deficiencies across all five of our veterans' homes shows that 91 percent were minimal with no actual harm, essentially a level B or below.

In fact, one of our deficiencies was for a burned out light bulb. Another was for a fryer that had been cleaned and replaced one inch from its original position.

I note that our system-wide pressure ulcer rates remain at or below 5 percent, approximately one-third of the national average of 15 percent for long-term care facilities.

According to the CMS Nursing Home Care Compare Survey, three of our five facilities have earned five star ratings with the remaining two achieving four star ratings, all by prioritizing robust census growth. We are proud of the care that we provide our veterans in Louisiana.

However, Ms. Chairwoman, we recognize that there is always going to be improvement or room for improvement. In a written, excuse me, in our written statement we provided some information about the escalating cost of medication, which we have covered here today is, something that we fully support.

The LDVA would also like to see greater support for our veterans' mental health and behavioral programs. We are experiencing a continued rise in the prevalence and acuity level of mental health and behavioral issues which negatively impact both clinical coordination and home admissions. In essence, there are plenty of veterans who we have to turn away because we simply do not have the capability to meet their needs.

Pilot studies to identify optimal staffing, infrastructure, and operations of enhanced geriatric psychiatric care capabilities are warranted and Louisiana is ready to lead this effort.

Ms. Chairwoman, veterans in our homes are not just patients. They are family members. They are heroes. Our staff's clinical competency and dedication ensures that their dignity is not only preserved but celebrated while they continue to receive high quality and safe care.

Robust oversight from engaged leaders and unwavering commitment of staff create a foundation of trust and respect that honors our Nation's promise and our state's promise to our veterans.

I want to thank you for your continued support of our veterans and the homes that serve them. I welcome any questions that you may have.

[THE PREPARED STATEMENT OF CHARLTON MEGINLEY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Secretary Meginley. As is my typical practice I will reserve my time until all other members have had a chance to ask their questions.

I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair.

Mr. Harries, I just wanted to start off with Mr. Taylor was here and seemingly introduced a new bill, and my understanding of the bill is that he wants to take $2 billion in funds that were appropriated to the U.S. Agency for International Development, or USAID, and reallocate those funds to the VA for State veteran homes construction grants. Is that a bill that you support or have you had a chance to look it over?

Mr. HARRIES. Yes. Actually, I have. The NASVH cannot determine where the money is going to come from. However, there is a huge need for more State veterans' homes across the country. If you think about it, and you are well-aware, the bolus or bubble of veterans coming at us in the age group we care for, it is not stopping. It is coming at us.

On top of that, with respect to the high-cost medication mitigation, more and more of these are coming through toxic exposures, cancer diagnoses, Parkinson's, very, very complex care.

More veterans' homes actually allows the VA to or accelerates the VA to complete their mission of reaching out to veterans across the country. Let us provide the footprint that they can build on.

Ms. BROWNLEY. Well, thank you for that. You know, and I agree with you. I think we need to provide more resources. I have worked very hard in my tenure in Congress to expand and extend long-term care. My veterans' home, my State veterans' home within my district, is an extraordinary place with many happy, happy, happy veterans and their spouses as well and so I agree with you.

I just, in terms of Mr. Harris' (sic) bill I just, kind of, feel as though, from my perspective anyway, that U.S. foreign assistance is essential, a component to our national security. I think veterans who serve abroad probably understand that very well in terms of what USAID does in fostering goodwill toward our Nation.

I think USAID literally saves lives by bringing food, medicine, and stability to impoverished nations, and I think the bill just represents a false choice between funding veteran programs versus global security and international cooperation.

Quite frankly, I think that we must fund both is my perspective and we can do both if we do so with rational tax policies that require millionaires and billionaires to pay their fair share rather than providing massive giveaways. I think that is what is happening right now as we speak under the dome here through reconciliation as we are working through a tax plan to give millionaires and billionaires great tax cuts at the expense of others.

I just wanted to State that for the record, and I will move on and wanted to ask you both with the question that I had asked Dr. Hartronft earlier when he was here. If there is a significant cut to Medicaid over the next 10 years, have your respective states analyzed the extent to which this may increase veterans' reliance on State veteran homes? If these cuts lead more veterans to turn to State veteran homes for long-term care services?

Mr. HARRIES. I am assuming the question is for me?

Ms. BROWNLEY. Yes, either one of you.

Mr. HARRIES. Well, first, we would want all veterans to come to the State veterans' homes.

Ms. BROWNLEY. Yes.

Mr. HARRIES. I mean literally.

Ms. BROWNLEY. Understood.

Mr. HARRIES. We do serve and provide a much higher level of service and quality of life. We firmly believe that I have seen it firsthand. With those Medicaid cuts, 75 percent of the veterans' homes are covered by CMS so therefore they would have a significant Medicaid population in the mix.

If the cuts are applied to long-term care limit levels at that point. We have done those studies to accommodate for that at this point but would be willing to look at that and any studies that do come forward.

Ms. BROWNLEY. Very good. I think I, you know, and this last week I visited several facilities in my district within our county hospital and, you know, they were talking about the devastation the hospital would undergo if these cuts were pursued.

They also were, sort of, in a wait and see mode to just, kind of, see what happens before they take any action, obviously, but they went through a quick laundry list of where the impacts would be. They would be pretty devastating and I guess my time is up and I yield back.

Ms. MILLER-MEEKS. Thank you very much. I thank your county hospitals for not responding to stuff that has not yet occurred. Thank you for that.

Again, I am going to apologize to the witnesses for members that are not here given the numbers of markups that are going on throughout.

I also appreciate that it seems that Mr. Harries and Secretary Meginley that you understood the point of my questioning to Ms. Silas regarding oversight, that oversight for State veterans' homes occurs far beyond just the VA or the HVAC Health Subcommittee or HVAC Committee here in Congress, that you have multiple regulatory bodies conducting oversight.

To your point Mr. Harries, it sometimes actually creates burdens and hurdles and lack of innovation or new processes. Again, I commend the VA and Dr. Hartronft for the progress they have made in clearing deficiencies, so I just wanted to recognize that.

Mr. Harries, how could VA health care be improved to address gaps in medication reimbursement at State veterans' homes?

Mr. HARRIES. How could it be improved? If the VA were to accommodate the State veterans' homes through as they do the private sector nursing homes by paying for, reimbursing for those high-cost medications.

Ms. MILLER-MEEKS. For medication that they cover outside——

Mr. HARRIES. Correct.

Ms. MILLER-MEEKS [continuing]. of the veterans' homes?

Mr. HARRIES. Exactly. My point is we are doing it for one party but we are not doing it for another and we are the party that is not getting that reimbursement.

There are states, and I have stories already in my previous testimony, and I believe there may be some in this one where veterans have been turned away because they have $100,000 medication or

a $28,000 medication coming in which it is the VA per diem rates that are paid. That is a financial loss for the facility. That loss has to be made up somewhere else, which would probably be in resident care, probably not adding another admission, and just the cascading effect.

I think the key thing is covering those medications as they are coming, and as I spoke earlier, the number of residents that we are seeing now, the number of patients coming to us with high-cost medications and complex comorbidities, such as, well, the reimbursement has got to come, especially with all the toxic exposures and Agent Orange exposures and such.

Ms. MILLER-MEEKS. Last month we discussed a pilot program, the Communities Helping Invest through Property and Improvements Needed for Veterans (CHIP IN) Act, which had been used to instruct a VA clinic next to the VA Medical Center in Omaha, Nebraska, and extending the CHIP IN Act from its pilot program for construction for either VA hospitals and/or VA clinics.

Even though the State veterans' home are a combination of State funding and VA funding, is this something that a little bit of out-of-the-box thinking that could be applied to construction grants for State veterans' homes?

Then I have got an extension to that question.

Mr. HARRIES. I do not see why not. It sounds like a fantastic idea.

Ms. MILLER-MEEKS. We might need to expand our potential legislation. The current interpretation of Federal regulations does not allow a State veterans' home to apply for a construction grant in order to begin new adult daycare health program. A home may only seek a grant to expand or replace a facility currently being used for adult day health care. What complications does this pose for State veterans' homes that want to provide adult daycare?

Mr. HARRIES. It cannot do it unless they pay for it entirely on their own and it is a sizable investment in care. Adult daycare, and we have talked about suicide prevention and mental illness with our veterans that are coming in, adult daycare, the medical model of adult daycare, the residents are assessed on a daily basis to make sure that does not happen.

It also takes out the isolation that causes a lot of suicides. It would be vital for us to be able to expand that program and have satellite offsite clinics available under outpatient or adult daycare facilities so that we can monitor and take care of those residents. Their life would be much better improved if we could do that.

Ms. MILLER-MEEKS. Thank you.

Secretary Meginley, several of Louisiana's State veterans' homes are in rural areas. What are challenges and best practices for coordinating transportation for veterans who need specialized care?

Mr. MEGINLEY. Yes, ma'am. One of our homes is in the rural area of Jennings. One of the challenges that we have, because it is in a rural area, is making sure that we have the appropriate staff. Obviously, making sure we have the Licensed Practical Nurses (LPNs), the Registered Nurses (RNs) to be able to come in.

We are having to pull from different metropolitan areas making sure that these individuals are well-funded, well-paid is something that we consistently work with our Louisiana civil service to make

sure that those folks are paid at least market rate at a minimum and offered additional co-pays as needed.

As far as getting them to the facilities, luckily, Bossier is okay. Our home in Bossier is next to Overton Brooks in Shreveport so they have easy access to the hospital. Reserve is close to New Orleans VA. Jackson is not too far from our Community-Based Outpatient Clinic (CBOC) in Baton Rouge, which is very well equipped, I think.

Yes, that is a problem. Something that we have talked about extensively is about rural transportation for veterans to VA hospitals and something that we have had since the conversations with our administrators about making sure that we can facilitate those needs.

Ms. MILLER-MEEKS. Thank you. I would yield. I know. I am sorry. She was telling me Dr. Morrison is here. Do I know Dr. Morrison is here? I was just about to say I yield the remainder of my time.

The chair now recognizes Dr. Morrison for 5 minutes for any questions she may have.

Ms. MORRISON. Thank you, Madam Chair.

Thank you to our witnesses for testifying today on the role of State veterans' homes play and caring for our aging veterans. You know, a key aspect that strikes me as fundamental to today's hearing is the importance of having robust data to review as we discuss opportunities to improve oversight and ultimately the quality of care in State veterans' homes.

I know several years have passed since the last hearing on this issue here in Congress with my colleagues, and I have had the benefit of being able to review data GAO compiled in their 2022 review, as well as data from research conducted in collaboration with the VA and other research entities.

I emphasize that we have this data as a result of intentional and consistent efforts to monitor the quality of care at State veterans' homes and conduct research in this area. As a result of these research and monitoring efforts, we are able to better understand elements such as the population of veterans that use State veterans' homes, how State veterans' homes are meeting needs in comparison to community nursing homes and VA's community living centers, how well State veterans' homes responded to the COVID–19 pandemic, and even what areas of operation oversight might warrant additional review.

Having spent over 2 decades of caring for patients as a physician myself, it is important to me that our next steps consider evidence-based strategies and place data and form responses at the forefront of our actions, so I want us to continue using the data available to us in hearings like the one we are having here today.

Equally and perhaps more critical in this particular moment, I think it is imperative that we continue to collect this data and not undermine the research that supports our collective pursuit of best practices and quality care for our veterans.

Secretary Meginley, in your testimony you discussed best practices for the State veterans' homes under your management. I appreciate that you began your statement affirming your state's unwavering commitment to safely and effectively managing State vet-

erans' homes and conclude expressing your willingness to continue working closely with your VA partners turn to ensure clinical quality and patient safety.

Can you elaborate a little bit more on how this partnership with VA has contributed to your ability to deliver high quality care in State veterans' homes?

Mr. MEGINLEY. Yes, ma'am. I will tell you all, I am not just a veteran. I am a patient of the New Orleans VA. That is where I go to all my healthcare. I have a phenomenal relationship with my administrator. I can call my administrator at midnight on a Friday night, which I have done, to ensure that a veteran who is having a mental health crisis is taken care of immediately.

My administrators both in Alexandria and Shreveport are very much the same. The rural health care question, recently I was at Monroe and the honeymoon period of my time ended very quickly when I got confronted about community care issues.

I contacted my administrator in Shreveport and gave him the questions that some of the veterans had had concerns about, and that administrator answered those questions within 72 hours and restored some of these processes to make sure that our rural veterans were getting the health care that they needed through the CBOC entity in Shreveport.

The same for Alexandria as well, so, ma'am, I think my relationship with my administrators is phenomenal, and I can call any of my VA partners in a heartbeat and the answers and the questions that I have will get taken care of without question.

I think that is one of the strengths. I am in Alexandria. I live on the north shore of Louisiana not too far from New Orleans. I have been to Shreveport almost a dozen times, and every time I go either myself or my deputy, who is behind me, go and visit the VA administrators and ask them what can we do for you as a state? We give them what our questions are as to how they can help us with our veterans as well.

To me, that is the forefront and the heart of everything that I do. As a State VA I cannot do my job without being intertwined at the hip with my VA administrators and my VA partners.

Ms. MORRISON. Thank you for that response. Colonel—Secretary, I should say, you also mentioned rigorous oversight is an element that supports your delivery of compassionate, high quality services.

Mr. Harries, you specifically cited the layers of oversight for State veterans' homes as a reason that they offer higher quality. Could each of you speak just briefly to the importance of collecting robust data at the Federal and State levels and how additional research informs the administration of the care provided at State veterans' homes?

Mr. MEGINLEY. Well, I will tell you this. My deputy and I, my deputy is a retired Army doc, by the way, on my staff, so I have an on-staff physician to be able to help me answer some of the questions.

You talk about data. We have been talking about data since day one, and I will tell you one of the most important pieces of data that has stuck with me over and over is the fact that we turn away 72 percent of veterans who have mental health issues. We do not have the capability to be able to take care of their needs.

When you start talking about those numbers—we talk about pressure ulcer rates. One of our homes had a very low pressure ulcer rate. We wanted to know why your rate was so much lower than the others. They were all still below the national average, but what were you all doing differently?

That data allowed us to go find the answers and take that best practice and put it and put it in the other four homes. We have also talked about, you know, other data points that would make our workforce stronger, our medication issues stronger, because as Mr. Harries talked about, prescription costs are extraordinary, particularly in some cases. Trying to figure out ways to make sure that our veterans are being taken care of, again, having the data is very vital to us. We live and die by data essentially every day so that we can make our homes better.

Ms. MILLER-MEEKS. Is there——

Ms. MORRISON. Well, I was hoping that Mr. Harries might comment, too, in——

Mr. HARRIES. Sure.

Ms. MILLER-MEEKS. Briefly, sir.

Ms. MORRISON [continuing]. 39 seconds left.

Ms. MILLER-MEEKS. The gentlewoman's time has expired.

Mr. HARRIES. I am a six sigma black belt, which means that I love data and the more data I can get the better. It is the way you are going to solve your problems. It is the way you are going to get there.

Before we close or you cut me off, what I do want to State is I have heard it once that VA has the largest compilation of health care data in the world. Utilize that. Let us look at that. Let us see what we can do to leverage that to make some improvements.

Ms. MORRISON. Thank you.

Thank you for your indulgence, Madam Chair.

Ms. MILLER-MEEKS. Thank you for yielding.

Members can always submit questions for the record, which I have done earlier so that I would not go over time.

Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. I thank you for having the hearing. I think this topic is an important one. With the colonel's answer to Ms. Morrison's question, I wonder how we can have the relationship that you described between your medical center and your State veteran home, how that relationship, how we can have that everywhere across the country.

Mr. MEGINLEY. Well, I will tell you, ma'am, it helps when you are a patient because I go in 1 day as a State secretary leader and the next thing I am getting my knee injected. I get a chance to see what they are doing.

Ms. BROWNLEY. Thank you. Yield back.

Ms. MILLER-MEEKS. Thank you.

I will recognize you in the future, sir.

Mr. MEGINLEY. I am sorry, ma'am.

Ms. MILLER-MEEKS. Sorry, chain of command. Two veterans ought to know.

Number one, again, I want to apologize. My sincere apologies to our witnesses, to the VA, to the secretary, to Mr. Harries for the

lack of members who are here. I thank the members who came. I thank you all very much.

When we set up hearings we do not necessarily know that there are going to be markups and there are numerous markups by numerous committees today. I am supposed to be over in one in Energy and Commerce but thank you for being here.

Thank you for your participation and taking the time in today's hearing. This actually is an extremely important topic, both given how much regulatory burden there is and oversight there is in health care and also the very important work that you do given the population that you serve and the increasing numbers of that population receiving access for care.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Hearing no objection, so ordered.

I thank all members and their witnesses for their participation today. This hearing is adjourned. Thank you so much.

[Whereupon, at 3:33 p.m., the subcommittee was adjourned.]

# A P P E N D I X

## PREPARED STATEMENTS OF WITNESSES

### Prepared Statement of Scotte Hartronft

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee. My name is Dr. Scotte Hartronft, and I am the Executive Director of the Office of Geriatrics and Extended Care at the Department of Veterans Affairs (VA). I am honored to discuss the strategic approach VA employs, which results in high-quality health care outcomes and support for the Nation's heroes at State Veterans Homes (SVH). SVHs are owned, operated, and managed by the states. VA's role as it relates to SVHs is as a support to ensure Veterans receive the high-quality care which meets the Department's standards, through annual certification and recognition surveys, Medical Sharing Agreements, and grants to construct, renovate, or repair State owned facilities.

Currently, the Department supports 172 SVHs, which administer a combined 166 Nursing Home Programs, 47 Domiciliary Care Programs, and 3 Adult Day Health Care Programs. To participate in the SVH program and its benefits, VA must formally recognize a care facility as an SVH through the certification process and a recognition survey. Along with compliance with VA standards, a recognition survey requires adherence to all applicable Federal, State, and local laws including the relevant professional standards for VA purposes to recognize the home as an SVH.

After formal recognition, VA conducts at least one unannounced annual survey at each facility to ensure compliance with VA standards. The VA surveys cover 200 clinical standards, fire and life safety standards, administrative standards, and fiscal standards. Many of the standards are based on the CMS nursing home standards but others are VA and SVH unique. Any areas of non-compliance identified on surveys are addressed through corrective action plans in collaboration with the Veterans Health Administration survey team. During the corrective action plan follow-up period an ad-hoc for cause full survey can be completed if felt necessary. Compliance with VA regulations under 38 C.F.R. part 51 and VA's survey and certification process is required for SVHs that provide nursing home care, domiciliary care, or adult day health care to remain eligible to receive per diem payments or participate in the State Home Construction Grant Program (SHCGP). VA's survey process mirrors the Centers for Medicare and Medicaid Services (CMS) for long-term care facilities.

VA offers support to SVHs by permitting recognized SVHs to enter into Medical Sharing Agreements with their local VA Medical Centers to procure additional clinical services or secure discounted pharmaceutical prices. The SVH's that are CMS certified also on average outperform the US nursing home star rating on their CMS surveys. To maintain SVH recognition, VHA may also provide funds to ensure adequate levels of nursing staff. In Fiscal Year 2024, VA approved $4.7 million for the 17 states and 47 SVHs that applied for Federal funds to support programs that hire or retain nursing staff.

SHCGP is a partnership between VA and the states to construct, renovate or repair state-owned and operated nursing homes, domiciliaries, and/or adult day health care facilities. VA provides reimbursement of up to 65 percent of allowable costs to states for the construction and renovation of SVHs. The number of awards provided each year depends on the number of projects, their costs, and the amount of appropriation received in the fiscal year. VA is responsible for determining the priority for funding facility improvements, which may include bed replacements, mold removal, and repairs to structural hazards to assist SVHs in proving high-quality care for Veterans.

**Conclusion**

In conclusion, VA remains steadfast in its dedication to continuous improvement in the oversight of SVHs. We appreciate the oversight from the Subcommittee and look forward to answering any questions you may have.

**Prepared Statement of Sharon Silas**

United States Government Accountability Office

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 2:15 p.m. ET
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# VA NURSING HOME CARE

# Opportunities Remain to Enhance Oversight of State Veterans Homes

Statement of Sharon M. Silas, Director, Health Care

GAO-25-108441

GAO Highlights

Highlights of GAO-25-108441, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

April 2025

# VA NURSING HOME CARE

## Opportunities Remain to Enhance Oversight of State Veterans Homes

### Why GAO Did This Study

Veterans—like many other Americans—rely on nursing home care to help meet their health needs as they age. In fiscal year 2023, VA paid about $1.5 billion for veteran nursing home care provided in state veterans homes.

This statement describes (1) oversight of state veterans homes; and (2) the status of VA efforts to implement GAO recommendations to strengthen oversight of state veterans homes.

This statement is based on GAO's November 2022 report (GAO-23-105167) on oversight of state veterans homes. To do that work, GAO conducted a nationwide survey to collect information on the 153 state veterans homes providing nursing home care. GAO also reviewed relevant laws and VA documents and interviewed federal and state officials, state veterans homes' officials, and other organizations involved with veteran care, such as veterans service organizations. For this statement GAO reviewed expenditure and utilization data for fiscal year 2023 and provided updates on the status of GAO's recommendations.

### What GAO Recommends

In its November 2022 report, GAO made four recommendations. VA agreed with the recommendations and implemented three of them. However, VA has not implemented a recommendation to identify additional enforcement tools to help ensure state veterans home compliance with quality standards and seek legislative authority to implement them, as appropriate.

For more information, contact Sharon M. Silas at silass@gao.gov.

### What GAO Found

The Department of Veterans Affairs (VA) is the only federal entity that oversees all state veterans homes. The Centers for Medicare & Medicaid Services (CMS) and state agencies also have an oversight role in some of these homes. While these homes are owned and operated by states, VA helps pay for care for eligible veterans and is required to ensure each home meets VA's quality standards. To do this, VA conducts regular inspections. Homes that do not meet standards can be cited for deficiencies. CMS also conducts inspections in homes that receive Medicare or Medicaid payments and can also cite deficiencies. For example, as of January 2022, CMS inspected 116 of the 153 state veterans homes. In response to GAO's 2022 national survey of state agencies that operate state veterans homes, 43 states also reported inspecting homes for compliance with state-specific regulations.

VA has implemented three of four GAO recommendations to strengthen oversight of state veterans homes. For example, VA developed a process to consistently follow up with homes that have not implemented their corrective action plans by agreed upon dates. However, VA has not addressed GAO's recommendation to identify a range of enforcement actions to bring state veterans homes into compliance with quality standards. Unlike CMS, VA lacks a range of enforcement actions (see figure). At the time of GAO's report, over 40 percent of homes were deficient in the same standard in both 2019 and 2021. VA had never used its only enforcement action, withholding payment, considering it too severe for most situations. VA officials said they were considering seeking legislative authority to take additional enforcement actions to ensure compliance with quality standards.

**Available Enforcement Actions for Department of Veterans Affairs and Selected Actions for Centers for Medicare & Medicaid Services, as of November 2022**

| VA ENFORCEMENT ACTIONS | SELECTED CMS ENFORCEMENT ACTIONS |
|---|---|
| • Withhold payment for daily veteran care | • Civil money penalties (fines for each day or instance of noncompliance)<br>• Denial of payment for all newly admitted eligible residents<br>• State monitoring (on-site monitor to achieve and maintain compliance)<br>• 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-25-108441

However, in 2025, VA officials said they are no longer pursuing the identification of additional enforcement actions and corresponding legislative authority. Instead, in 2024 VA developed a new enforcement plan that strengthens timelines and increases the amount of follow-up with homes that have deficiencies. However, the plan does not include a mechanism to compel compliance with VA's quality standards.

GAO maintains that having a range of enforcement options would help VA meet its program goals, align VA's practices with CMS's, and help VA ensure veterans receive quality care in state veterans homes.

April 29, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee:

I appreciate the opportunity to be here today to discuss the Department of Veterans Affairs' (VA) oversight of state veterans homes.

Like many older Americans, aging veterans may have extensive health care needs and require skilled nursing home care to meet their daily needs. For many of these veterans, VA provides or pays for nursing home care in three settings: VA-owned and -operated community living centers, publicly or privately owned community nursing homes, and state-owned and -operated state veterans homes.[1]

In fiscal year 2023, VA spent almost $8.4 billion for approximately 36,000 veterans who required skilled nursing and personal care in an institutional setting. More than 40 percent of these veterans—almost 15,000—received this nursing home care in state veterans homes at a cost of about $1.5 billion. To receive VA payments, the 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 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.

Over the past several years, we reported on opportunities for VA to enhance its oversight of state veterans homes to ensure aging veterans receive high-quality care.[2] My statement today summarizes findings from our most recent report from November 2022. It describes

[1]In general, the three settings provide similar nursing home care, in which veterans receive skilled nursing care, recreational activities, and other services. While the cost of care varies across the three settings, in fiscal year 2023, the average daily cost for veterans receiving VA- supported nursing home services was lowest in state veterans homes.

[2]See GAO, *VA Nursing Home Care: Opportunities Exist to Enhance Oversight of State Veterans Homes*, GAO-23-105167 (Washington, D.C.: Nov. 14, 2022); GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, GAO-21-191 (Washington, D.C.: Nov. 30, 2020); and 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).

1) oversight of state veterans homes and

2) the status of VA's efforts to implement our recommendations to strengthen oversight of these homes.

To perform the work for our November 2022 report, we reviewed federal documents, conducted a national survey of officials from the state agencies that operate 153 state veterans homes, and interviewed officials from VA and other organizations, including state veterans homes and veterans service organizations.[3] We reviewed VA and CMS documents about state veterans home inspection policies and processes, and documents on VA's oversight process for state veterans homes (modeled after CMS's system). We also reviewed applicable statutes and regulations pertaining to VA's oversight authorities. Further details on our scope and methodology can be found in our November 2022 report. For this statement, we also reviewed VA's fiscal year 2025 congressional budget submission to obtain fiscal year 2023 data on state veteran home utilization and expenditures. Additionally, we reviewed written statements VA provided about the status of its efforts to implement our recommendations.[4]

The work on which this statement is based was performed 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 supports state veterans homes by providing per diem payments for each day that an eligible veteran is receiving care and has an overnight stay, with certain exceptions.[5] VA also provides grants to construct, acquire, remodel, or modify state veterans homes, and payments to

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

[4]We have had multiple communications with VA about the status of their efforts to address our recommendations from 2023 to March 2025.

[5]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.

states for the hiring and retention of nurses.[6] State veterans homes are owned and operated by the state in which they are located. Federal statute prohibits VA from having authority over the management of or control of any state home.[7]

Depending on the veteran, VA pays the full or partial cost of state veterans home care.[8] 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.

## VA, CMS, and States Can Each Have a Role in Overseeing State Veterans Homes

VA is the only federal entity that oversees all state veterans homes and must ensure they meet applicable quality of care and other standards in order to provide them with payments. Any home that participates in Medicare or Medicaid is also overseen by CMS to ensure they meet the federal quality standards required to receive those payments. Finally, states may subject homes to their own regulations—and, in 2022, we found a majority did.

### VA Oversight

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.[9] 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. The VA medical center of jurisdiction—usually the medical center located closest to the home—is responsible for helping veterans make decisions about nursing home care, responding to

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

[7]38 U.S.C. § 1742(b).

[8]According to VA policy, its payments are equal to the lesser of the annual basic per diem rate—determined annually on a fiscal year basis—or 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 disability—which is an injury or disease that was incurred or aggravated while on active duty—and for veterans with service-connected disabilities rated at 70 percent or more. See 38 U.S.C. § 1710A(a). Unless reauthorized, this statutory requirement will terminate on September 30, 2025. For these veterans, VA makes prevailing rate per diem payments. See 38 C.F.R. § 51.41 (2024).

[9]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).

inquiries from state veterans home management, referring management to the appropriate VA office, among other things. Each VA medical center resides within regional networks called Veterans Integrated Services Networks, and GEC works with liaisons within each regional network to address state veterans home quality issues, as needed.

As a function of its oversight, VA contracts with a third party to conduct inspections that determine the extent to which state veterans homes meet relevant nursing home quality of care standards.[10]

- State veterans homes must first be inspected for recognition, which makes them eligible to receive VA's per diem. 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.
- Once a home is recognized by VA, subsequent inspections are generally unannounced and typically occur annually or in response to a specific incident or complaint. As we reported in 2022, VA policy calls for inspections of state veterans homes on a regular schedule, approximately yearly, to assess compliance with 189 standards across 16 categories.
- Additionally, VA conducts for-cause inspections—which are typically unannounced—that may arise from complaints or facility reported incidents.

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 inspections of nursing homes. VA rates each deficiency for its scope—which indicates whether the deficiency is isolated to one patient, a pattern, or widespread; and its severity—which 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. As we reported in 2022, homes with an accepted corrective action plan in place are

[10]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.

"provisionally certified" and are eligible to continue to receive per-diem payments.[11] In the event of continued non-compliance, VA may withhold its per diem payments to state veterans homes. This requires approval by the VA Secretary and may happen if, for example, the home has an egregious deficiency or a history of well-documented non-compliance.

## CMS Oversight

While VA is the only federal agency to inspect 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.[12] We reported that, as of January 2022, 76 percent of state veterans homes were also inspected by CMS.[13] CMS enters into agreements with state survey agencies to inspect these homes for compliance with federal standards, as it does for all nursing homes that receive Medicare or Medicaid payments. CMS policy calls for the inspection of nursing homes, including state veterans homes, every 15 months or less. CMS inspections assess compliance with federal quality standards or may be conducted for cause.

Like VA, CMS requires state veterans homes to develop a corrective action plan for each deficiency in a routine or for-cause inspection, including anticipated dates of correction. Depending on the scope and severity of the deficiency, the state survey agency may revisit the home on behalf of CMS to ensure it implemented the plan and corrected the deficiency. Additionally, unlike VA, CMS has the authority to impose a range of enforcement actions on state veterans homes with deficiencies.

## State-Specific Oversight

In response to our national survey conducted in early 2022, state officials in 43 states indicated that they also conduct their own state-specific

[11]Provisional certification allows homes to receive per-diem payments while they address deficiencies cited in an inspection through the corrective action plan process. See GAO-23-105167.

[12]See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2024).

[13]GAO-23-105167.

inspections in addition to the oversight conducted by VA and CMS.[14] States that reported conducting some kind of oversight said they did so through either routine inspections based on state-specific nursing home quality regulations, for-cause inspections, or both. In contrast, 7 states reported they did not have either state-specific nursing home quality regulations or for-cause inspections.[15]

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), or suspending admissions to the home (27 states).[16]

[14]We conducted our survey in March through April 2022. At the time of our survey, the 7 states that said they did not conduct their own inspections of state veterans homes were Louisiana, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, and Utah. We deployed the survey in all 50 states and Puerto Rico (Washington, D.C., does not have any state veterans homes), but Wyoming was then excluded from analysis because, at the time of our survey, it reported not having any state veterans homes that provide nursing home care. For our reporting purposes Puerto Rico is included in state summary counts when applicable. For the full survey results including lists of state oversight policies and of all 153 state veterans homes that provided nursing home care at the time of our survey—including their location, number of nursing home beds, and whether they were certified by CMS—see GAO-23-105167.

[15]Like all states, these states' homes are subject to VA inspections and some also receive CMS inspections. At the time of our survey, among the 25 state veterans homes that provide nursing home care in these states, 8 of them—those in New Hampshire and Missouri—were not inspected by CMS because they were not Medicare or Medicaid-certified, and only received oversight from VA.

[16]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).

## VA Has Taken Recommended Actions to Strengthen Oversight, but Has Not Expanded Enforcement Options to Help Ensure Compliance with Standards

In our November 2022 report we identified four areas in which VA could improve its oversight of state veterans homes. Specifically, we recommended that VA (1) improve its data analysis capabilities; (2) improve the effectiveness of corrective action plans by developing a process for following up on plans that lack evidence of timely implementation; (3) ensure its efforts to centralize oversight processes are successful by bringing them into alignment with VA policy; and (4) identify additional enforcement actions that could help ensure state veterans home compliance with quality standards and seek legislative authority to implement them, as appropriate. VA has implemented the first three of these recommendations.

### VA Has Implemented Three GAO Recommendations to Strengthen Oversight of State Veterans Homes

As of March 2025, VA has implemented three of the recommendations we made in our November 2022 report. In doing so, VA has strengthened its oversight of state veterans homes in the following three areas:

- **Data analytic capabilities.** We found that VA officials were limited in their ability to efficiently analyze state veterans home oversight data. We recommended that VA develop a plan to ensure its data system would have the capabilities to aggregate and analyze state veterans home data by multiple units of measurement, including by state and home, and across survey years. In September 2023, VA provided evidence of a plan for developing a system for state veterans home data.
- **Oversight of corrective action plans.** We found that VA officials did not have a process for following up with state veterans homes about accepted corrective action plans, which are required for all deficiencies cited during a VA inspection. We recommended that VA implement a process for consistently following up with homes that have not implemented their corrective action plans by agreed upon dates. In September 2023, VA provided us with evidence that the agency developed and implemented a process to follow up with homes within 1 month of the agreed upon completion date. VA also provided evidence that they have improved their survey tracking tool to help staff manage these dates.
- **Formalizing its oversight structure.** We found that VA had not formalized changes in its oversight structure which it initiated in January 2022. At that time, VA began centralizing oversight of state veterans homes by shifting responsibilities for many tasks previously conducted by the 105 representatives at the VA medical center of

jurisdiction to four new national program managers in VA's central office. VA officials said that centralizing state veterans home oversight at the national level would help improve data consistency, communication, and planning, while ensuring all oversight is aligned in a single national office. As discussed in our November 2022 report, we found these centralization efforts to be promising and recommended that VA formalize this new oversight structure, which it did. Specifically, VA issued an interim notice in October 2023 outlining its centralization efforts and new oversight requirements for state veterans homes. This notice, renewed in August 2024, serves as policy until a new state veterans home directive is published by VA.

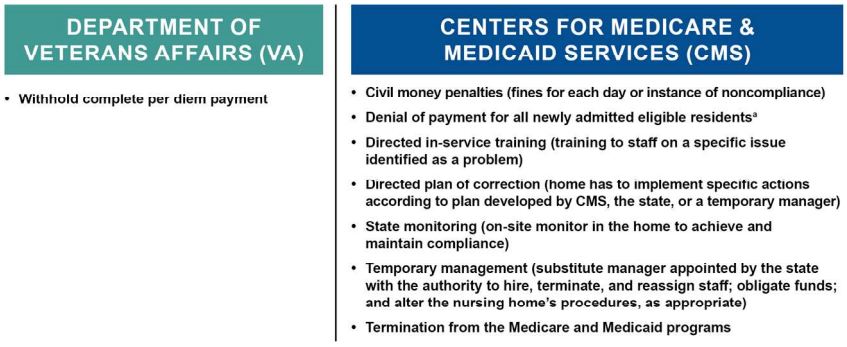
## VA Has Not Implemented GAO Recommendation to Identify and Implement a Range of Enforcement Actions

We reported in 2022 that VA could further improve compliance with quality standards by identifying a range of enforcement actions. VA officials said its one available action—withholding per diem payments—has never been used because they considered it too severe for most situations, as it could result in veterans being transferred out of the state veterans home. At the time of our 2022 report, VA officials said it had been over a decade since the agency considered withholding a noncompliant home's per diem.[17]

As we reported in November 2022, VA's enforcement options are limited compared with CMS (see fig. 1). CMS can impose civil money penalties of varying amounts, rather than withhold payments, among other enforcement actions. In this way, CMS has a range—from mild to severe—of enforcement actions available to help get nursing homes in compliance. These actions 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 we interviewed said due to the difference between VA and CMS enforcement powers, they were more concerned about deficiencies cited by CMS than by VA.

[17]Since withholding per diem payments could result in residents being transferred out of the home, officials told us in 2022 that this 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. The Secretary of VA would have to approve the withholding of per diem payments, according to VA officials.

**Figure 1: Enforcement Actions Available for VA and Selected Enforcement Actions Available for CMS for Noncompliance with Quality Standards, as of November 2022**




Source: GAO analysis of VA information and 42 U.S.C. §§ 1395i-3(h), 1396r(h); 42 C.F.R. § 488.406 (2021). | GAO-25-108441

[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.

Having a range of enforcement actions could help VA tailor its enforcement for the scope and severity of deficiencies identified. In our analysis of deficiencies cited in VA inspections, we found deficiencies ranged in their scope and severity:

- The most common scope and severity ratings for deficiencies in both 2019 and 2021 were lower-level ratings—isolated in scope and no actual harm.
- However, over 21 percent of the deficiencies with corrective action plans that were past the due date in 2021 were rated as causing actual harm.
- Over 40 percent of homes for which we had annual inspection data from both 2019 and 2021 were cited for the same deficiency, meaning they failed to meet the same standard in both years.

The range of deficiencies' scope and severity ratings indicate that some deficiencies may be more appropriately addressed with less severe actions than complete withholding of per diem payments from the home.

As such, in our November 2022 report, we recommended VA identify additional enforcement actions and seek legislative authority to implement them, as appropriate. VA concurred with this recommendation, and officials told us during our audit work they were considering a legislative proposal to Congress for the authority to impose fines or withhold a percentage of per diem payments to address noncompliance with quality standards. However, VA officials said in 2025 they are no longer pursuing any changes to current statutes or regulations.

Instead of identifying new enforcement actions and pursuing legislative authority, in 2024 VA developed a new enforcement plan to strengthen timelines, increase the amount of follow-up with homes that have deficiencies, provide VA medical centers the option to pause admission referrals, and allow VA to "delay" granting provisional certification to a home.[18] While these actions might enhance oversight of state veterans homes, they do not provide VA with the range of tools needed to compel compliance with quality standards. Instead, VA is limited to the one compliance tool it already has in place—withholding a home's per diem payments—the most severe penalty.

We maintain that having a range of enforcement options would give VA the tools to align enforcement actions with the scope and severity of the deficiency. Such a process would help ensure compliance and fiscal integrity, one of VA's goals for its state veterans home program. It would also align VA's practices with those used by CMS, which uses a range of remedies that allow it to account for the scope and severity of a deficiency.[19] With a range of remedies, VA would be better positioned to compel state veterans homes to address issues of noncompliance, better ensuring quality care for aging veterans.

In conclusion, while CMS and states can have an oversight role for state veterans homes, VA is the only federal entity that oversees all state

[18]According to VA officials, VA medical centers may pause admission referrals on a case-by-case basis and would still be able to receive referrals from other sources. Per diem payments are not withheld unless provisional certification is denied.

[19]VA generally used the CMS model for developing its inspection methods. See 42 U.S.C. §§ 1395i-3(h)(2)(B), 1396r(h)(3)(C), 42 C.F.R. § 488.406 (2024).

veterans homes. While the department has taken steps to improve its oversight, VA's oversight could be strengthened if it had a range of available enforcement actions to help ensure its standards are met. We will continue to monitor VA's efforts to address this recommendation.

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you may have.

## GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas at silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Karin Wallestad (Assistant Director), Erin C. Henderson (Analyst-in-Charge), Topher Hoffmann, and Jennifer Whitworth.

**Prepared Statement of Ed Harries**

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

*"Caring for America's Heroes"*

Testimony of
**ED HARRIES, PRESIDENT**
**NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)**

Before the
**HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH**

**April 29, 2025**

Chairwoman Miller-Meeks and Ranking Member Brownley:

As President of the National Association of State Veterans Homes (NASVH), thank you for the opportunity to testify today before the House Veterans' Affairs Subcommittee on Health regarding ways to strengthen State Veterans Homes (SVHs) by removing unnecessary bureaucratic obstacles and enhancing long term services for aging and disabled veterans.

As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our Homes through education, networking, and advocacy. In addition to my role as President of NASVH, I work full time as the Executive Director/CEO of the Tennessee State Veterans Homes, which includes five SVHs in Murfreesboro, Humboldt, Knoxville, Clarksville, and Cleveland.

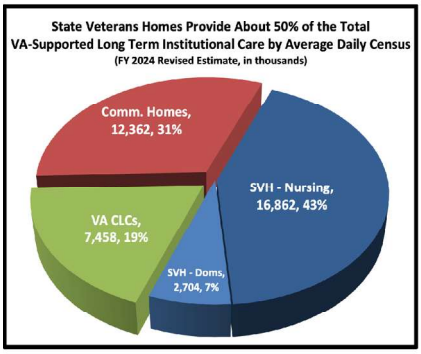
**BACKGROUND OF THE STATE VETERANS HOME PROGRAM**

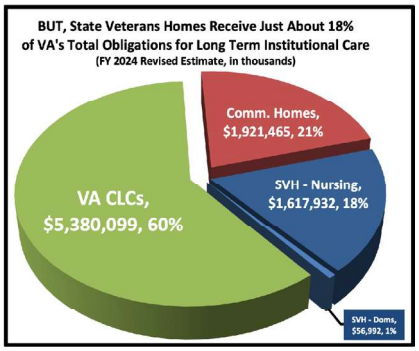
Madame Chairwoman, the State Veterans Homes (SVH) program is a partnership between the federal government and State governments that dates back to the post-Civil War period. Today there are 172 VA-recognized State Veterans Homes across the nation operating 166 skilled nursing care programs, 47 domiciliary care programs, and 3 adult day health care (ADHC) programs. NASVH is the only organization that represents their collective interests, and our membership is expected to continue growing as new Homes seek VA recognition.

To help cover the cost of care for veterans in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and ADHC. For veterans who have service-connected disabilities rated 70% or greater, VA has a statutory obligation to provide nursing home care and the law requires VA to reimburse SVHs – as well as private contract nursing homes – at higher "prevailing rates" intended to cover the full cost of caring for these severely disabled veterans.

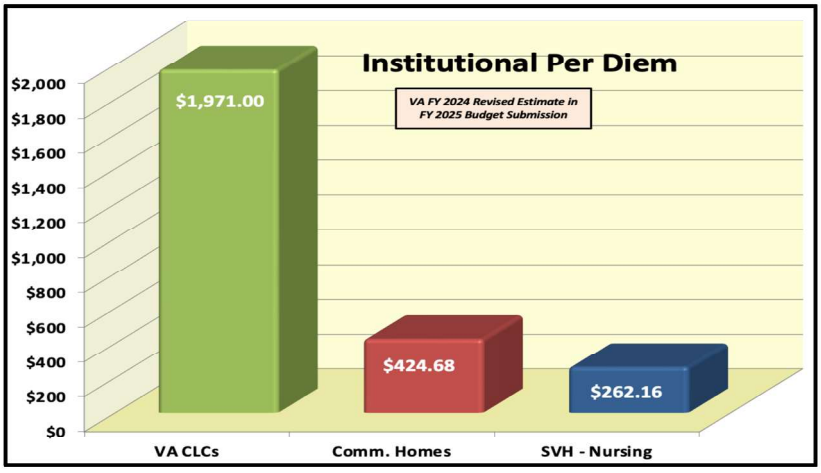
Today, there are over 30,000 authorized State Home beds providing a mix of skilled nursing and domiciliary care, which accounts for **half** of all VA-supported institutional long-term care for our nation's veterans, according to VA's most recent FY 2025 budget submission. However, in

providing this care, State Veterans Homes only consume about 18% of VA's total funding for veterans' long-term nursing home care. It's clear that the State Home program provides significant value to VA in meeting their obligations to the men and women who served.

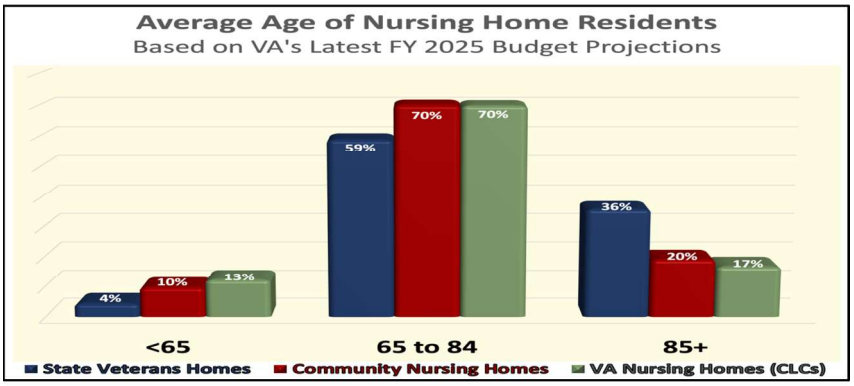



Furthermore, according to VA's FY 2025 budget, the institutional per diem for SVH skilled nursing care is currently $262; by comparison, the rate for private sector community nursing homes (CNHs) is $424, about 60% higher, and the rate for VA's Community Living Centers (CLCs) is $1,971, about 750% higher. Although there are important differences among these programs that account for some of these cost differences, there's no question that the SVH partnership plays a vital role by leveraging VA's appropriated funding with State matching funds for the benefit of the veterans we all serve.

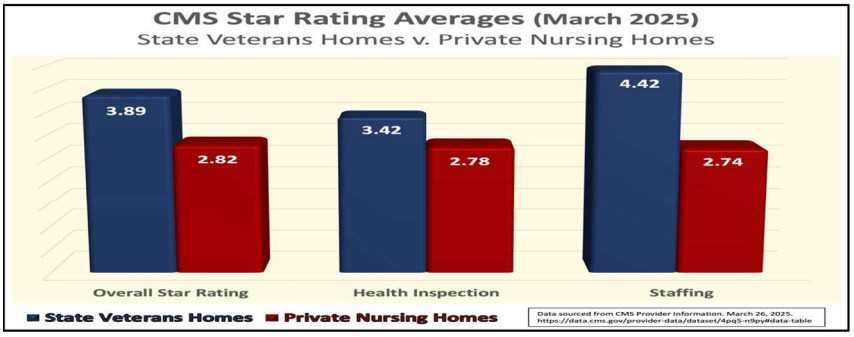


VA data shows that SVHs care for a significantly older veteran population than either VA CLCs or contracted community nursing homes. The number of veteran residents aged 85 or older in SVHs is about twice as high a percentage compared to VA's CLCs or private community nursing homes. State Homes also provide significantly more long-stay care and more end-of-life care compared to CNHs and CLCs, as would be expected for their older veteran population.

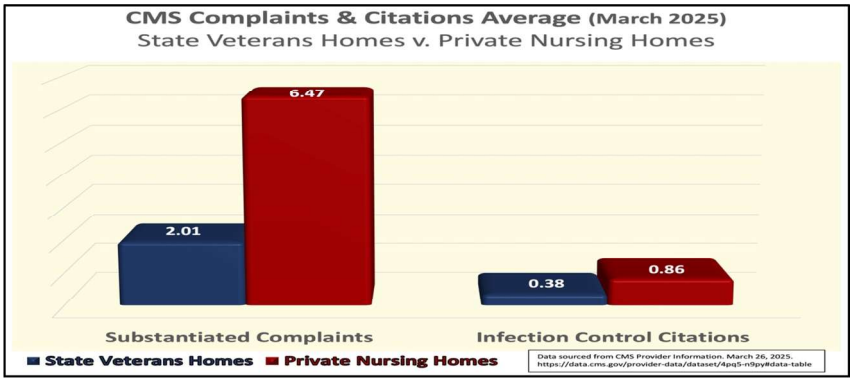



**SAFETY AND QUALITY COMPARISONS**

Studies and statistics continue to indicate that State Veterans Homes, on average, are safer, have higher quality ratings, and receive fewer substantiated complaints and citations compared to community nursing homes. According to the most recent data from the Centers for Medicare and Medicaid (CMS), approximately 70% of SVHs are rated by CMS as 4- or 5-star facilities, with an average rating of 3.9 out of 5 stars. By comparison, just 35% of CNIIs received 4- or 5-star ratings, with an average rating of just 2.8 stars. SVHs received an average rating of 3.4 stars for health inspections, compared to 2.8 stars for CNHs. In terms of meeting staffing requirements, SVHs received an average of 4.4 stars – with almost 90% receiving either a 4- or 5-star rating, compared to just 30% of CNHs, whose average rating was only 2.7 stars.



State Veterans Homes also significantly outperformed community nursing homes in terms of the number of complaints and citations received. According to CMS data, CNHs had more than three times the number of substantiated complaints compared to SVHs on average and more than double the number of infection control citations on average.




These quality and safety measures are also borne out in a recent study published in *The Journal of the Post-Acute and Long Term Care Medical Association (JAMDA)* in February 2024. The study looked at COVID-19 infections and deaths in nursing homes between May 2020 and July 2022. It found that the average number of COVID cases per 100 beds in SVHs was 58.0 compared to 73.6 in CNHs, indicating that SVHs were more successful in preventing the entrance and spread of COVID compared to CNHs.

The study found that the average number of COVID deaths per hundred beds was approximately the same, with 9.6 deaths in SVHs and 9.7 deaths in CNHs. The researchers noted that the higher mortality rate in SVHs could be explained by the fact that, *"...the typical demographic of SVHs are men, who compared with women suffer an overall mortality disadvantage that only increases in old age."* In fact, State Homes have an enormously higher percentage of men compared to community homes, and as stated above, SVHs also have a significantly older population of veterans compared to CNHs. Further, aging veterans typically have a greater number of comorbidities compared to similar aged civilians.

**OVERSIGHT OF STATE VETERANS HOMES**

One of the reasons that State Veterans Homes offer higher quality compared to community nursing homes (CNHs) is that SVHs have more layers of oversight. CNHs are primarily overseen by CMS, which contracts with the States to conduct an annual inspection survey. By contrast, State Homes have significant oversight regularly performed by VA, CMS and the State government which owns the Home, in addition to other federal, state, and local governmental entities that also monitor and inspect aspects of SVH's operations.

As required in statute, VA performs a comprehensive inspection survey of each State Veterans Home annually to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of each Home's facilities, services, clinical care, safety protocols and financial operations.

VA has extensive regulations covering every aspect of SVH operations. 38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210, provides a description of the standards for skilled nursing facilities that every State Veterans Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA's annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NPFA) Life Safety Codes and Standards. Finally, VA surveys and inspections conduct a financial audit concerning the Homes' financial operations and to ensure proper stewardship of residents' personal funds. There are also detailed regulations for domiciliary and adult day health care programs run by State Veterans Homes.

Every instance of non-compliance found with any of the hundreds of regulatory standards – regardless of whether it is unlikely to result in harm or whether it can be corrected on the spot – is documented and cited as a deficiency in the VA inspection report provided to the Home and the State government. In response, the SVH must provide VA with a corrective action plan (CAP) which explains how all violations will be remedied with a timeline for action. Subsequently, the SVH is required to provide VA evidence that it has completed the CAP to continue receiving per diem payments.

About 75% of State Veterans Homes are also certified to receive Medicare support for their residents and must undergo regular inspections by CMS to assure resident safety and quality care. The CMS inspection survey process covers more than 90% of the same clinical life and safety sections of the VA inspection survey in a week-long inspection that, like the VA inspection survey, is not announced in advance. All deficiencies identified by the CMS inspection must be corrected as a condition of continuing to receive CMS financial support.

In addition to the VA and CMS inspections, State Veterans Homes are also subject to both regular and periodic inspections and audits from the Inspector General of the Department of Veterans Affairs, and the Civil Rights Division of the Department of Justice.

Since SVHs generally function within a state's department or division of veterans' affairs, public health, or other accountable agency, they must also comply with all state-specific regulations. According to GAO, about 85% of SVHs are subject to either annual or "for cause" inspections by their states. Further, these SVHs typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public body. State Veterans Homes also have regular focused inspections from state and local authorities examining their fire safety preparedness, pharmaceutical practices, health and sanitary protocols, food safety practices and other public health and sanitization protocols.

**OVERSIGHT VS. OVERREGULATION**

While oversight is a necessary component of any well-run organization, it must be balanced against the dangers of overregulation. In State Veterans Homes, as in all nursing homes, proper oversight can help to ensure quality and safety. However, there can come a point where increased oversight becomes overregulation, which can have unintended consequences that undermine care delivery and operational efficiency.

**Administrative Burden**
Excessive oversight often requires nursing homes to dedicate significant time and resources to compliance tasks, such as completing detailed reporting, responding to audits, and preparing for frequent inspections. Community nursing home administrators spend an estimated 20 -30% of their time on regulatory compliance and reporting, diverting focus from resident care and staff management. Research published in *Health Affairs* (2019) found that U.S. nursing homes spend an average of 19.2 hours per week per facility on compliance-related documentation—translating into an immense amount of time that could otherwise be allocated to direct care. State Veterans Homes that are regularly inspected and certified by both VA and CMS are doubly impacted as they are scrutinized by and report to two independent regulatory entities, as well their States.

**Financial Strain**
Compliance with overreaching regulations increases operational costs, particularly for smaller or nonprofit facilities (which would include State Veterans Homes). Costs include hiring additional staff for documentation and compliance monitoring, investing in compliance software, or paying fines for minor and isolated infractions. This can lead to budget cuts in critical areas like staffing or facility maintenance, potentially lowering care quality and safety. According to a 2023 report by the American Health Care Association (AHCA), over 50% of nursing homes are operating at a financial loss, with nonprofit and government-operated facilities being the most vulnerable.

**Staff Burnout and Turnover**
Overregulation can create a high-pressure environment for staff, who face constant inspection survey and documentation demands, which can contribute to burnout and high turnover rates, disrupting staff continuity. Studies from the *Journal of Nursing Regulation* linked high levels of regulatory burden to increased moral distress among frontline staff and administrators alike.

**Defensive Practices**
Overly burdensome regulations have forced some nursing homes to focus on compliance over resident care to avoid citations, potentially leading to overly cautious or impersonal practices. For example, staff might limit resident activities to prevent falls, thus reducing residents' quality of life, or utilize medications to manage behaviors rather than addressing root causes. Excessive oversight can discourage facilities from adopting innovative care models or technologies due to regulatory hurdles or fear of noncompliance. For example, a RAND study in 2020 noted that facilities hesitant to adopt telehealth, personalized dementia interventions, or adaptive care models often cited fear of noncompliance as a primary barrier. In SVHs, where complex care needs and behavioral health conditions are more prevalent, innovation is not just beneficial—it's essential.

**Erosion of Relationships**
Excessive regulatory monitoring can foster a dynamic of distrust between regulators and facility staff, which can compromise collaboration that would ultimately benefit our deserving veterans. Oversight should focus on high risk facilities, streamlining reporting, and must prioritize outcomes and quality of life-based metrics over bureaucratic compliance.

While good governance of any organization must include thorough and effective oversight, a point upon which NASVH, the States and VA all agree – overregulation can undercut its efficacy. Its important to remember that State Veterans Homes are not "just" nursing homes—they're specialized long-term care environments for aging veterans with service-connected conditions, often dealing with PTSD, traumatic brain injuries, and other complex comorbidities. Our regulatory framework must reflect that particular reality, emphasizing flexibility, clinical judgment, and partnership—not just paperwork.

**CHALLENGES FACING STATE VETERANS HOMES**

**High Cost Medications**

Currently, VA is required to furnish drugs and medications for veterans residing in SVHs who are receiving the basic per diem if the veteran: 1) is rated 50% or greater; 2) needs the medication for a service-connected disability; 3) is receiving VA Aid and Attendance benefits; or 4) has been determined by VA to be catastrophically disabled. If the veteran is seriously disabled (70% service connected or greater) and the Home is receiving the prevailing rate for that veteran, VA will **not** furnish or reimburse the cost of any medications since a small portion of the prevailing rate is intended to cover the cost of medications. However, as pharmaceutical breakthroughs continue, more veterans now require and receive extremely expensive medications that can cost more than the entire prevailing rate paid to the State Home.

For example, the Iowa State Veterans Home is caring for a 55-year-old service connected Air Force veteran who suffers from Crohn's Disease. Fortunately, he is receiving a drug called Stelara, which is administered through IV infusion, to help control his symptoms. However, this medication costs about $5,000 a week, for a total cost of over $20,000 a month. Despite the financial burden, the Iowa State Home decided to care for this veteran at a significant operating loss per day; but that likely means the Home will have to cut costs somewhere else. For example, they might be forced to admit fewer deserving veterans, their spouses, or Gold Star parents; or perhaps cut back on social, recreational, or other non-clinical services that contribute to their quality of life.

This same situation is occurring in State Veterans Homes across the country. In some instances, the Home has had to absorb the cost, impacting its ability to care for other veterans. In other cases, deserving veterans have been denied a choice of where to spend their final years because VA won't continue to pay for their medications at a State Veterans Home.

That's why NASVH strongly supports the *Providing Veterans Essential Medications Act* (HR 1970), legislation that would correct this inequity in the law. We'd like to thank you, Chairwoman Miller-Meeks, and Congressman Pappas for introducing this commonsense legislation that would empower veterans who need high cost medications to receive necessary skilled nursing care in the facility of their choice. It would alleviate a financial burden placed on

State Veterans Homes and provide equity between private contract nursing homes and State Veterans Homes for seriously disabled veterans who rely on very expensive drugs and medications.

Madame Chairwoman, NASVH was surprised and disappointed that the VA witness at the Subcommittee's March 11 legislative hearing testified in opposition to your legislation. We have been discussing this problem and possible solutions with VA for several years. In fact, during meetings and conversations with multiple VA leaders – including the previous Secretary, the current Acting Under Secretary for Health and multiple Geriatrics and Extended Care (GEC) staff – they not only indicated VA understood the problem but stated on multiple occasions that they were interested in solving it with NASVH; they even set up a working group to seek a solution. The technical concerns raised by VA during the Subcommittee hearing could all be easily overcome with clarifications and additional legislative language to avoid unintended consequences. In addition, VA's objection to the proposed reimbursement methodology in your legislation is puzzling since it is based directly on the methodology in contracts that VA has signed with private community nursing homes. NASVH remains ready to work with this Subcommittee, VA, and other stakeholders to address any and all concerns so that this critical legislation can move forward.

**VA's Failure to Implement Sharing Agreements**

Public Law 117-328, enacted in December 2022, required VA to create a standardized process for State Homes to enter into sharing agreements with VA medical facilities providing medical services to veterans in SVHs. Unfortunately, VA's cursory implementation of this legislation did not resolve the problem. Since the *Providing Veterans Essential Medications Act* would allow State Homes the option to have VA provide them with high cost medications, a sharing agreement between the SVH and VA would be required. Unless VA fully commits to resolving this longstanding problem with sharing agreements, this provision of the legislation might be ineffective. NASVH believes additional congressional oversight or legislation will be required to end this problem and we would be pleased to work with the Subcommittee in this regard.

**Specialty Care for Veterans in State Homes**

Another problem State Homes must overcome is VA's failure to cover the cost of specialty care for veterans in SVHs. Although VA is required by law to pay for specialty care, especially when the care is due to a service-connected condition, in practice VA is regularly refusing to cover the cost for veterans to receive certain specialized health care services, including psychiatric care.

For example, VA has interpreted mental health services to include psychiatric care services and has stated that there are no specified "specialty" mental health services that the VAMC may provide to eligible residents without a signed written sharing agreement with the SVH. Psychiatric services are outside the scope of primary care services provided in the SVHs and, therefore, should be considered and treated as specialty care, similar to cardiology and urology specialty care services. VA's current interpretation is not right, and it is not oriented for the benefit of the veterans we care for. We would like to work with this Subcommittee to explore legislation to mandate that VA pay for all specialty care – including psychiatric care – for veterans residing in State Veterans Homes.

**Financial Challenges**

Many State Veterans Homes face continuing and significant financial challenges, in part because they have never fully recovered from the severe impacts of the COVID pandemic that increased costs, while reducing revenues when new admissions were suspended. To help address this problem, NASVH supports an increase in the basic per diem rates paid to SVHs. Under the law, VA is authorized to pay a basic per diem that covers up to 50% of the cost of a veteran's care, however the value of the basic per diem has eroded in recent years to the point that it is now equivalent to less than 30% of the actual cost of care, and as low as 20% in some states with higher costs-of-living. NASVH would welcome conversations with the Subcommittee about potential legislation that would set the basic per diem rate permanently at 50% of the daily cost of care.

Another resource challenge impacting State Veterans Homes is the lack of matching funding from the federal government for the State Home Construction Grant program. Currently, VA has a backlog of almost $2 billion in federal matching grants for States that have already secured their share of funding for the construction, rehabilitation, and repair of State Veterans Homes. However, Congress appropriated only $171 million this year even as the need continues to grow. It is imperative that Congress increase funding to catch up and eliminate the backlog of pending State Home Construction Grants. NASVH strongly recommends that Congress appropriate at least $650 million for FY 2026 to fund half of the pending Priority Group 1 grant requests.

**Staffing Challenges**

One of the biggest challenges facing State Veterans Homes is the inadequate number of clinical professionals, a problem for all health care institutions. Current staffing shortages are impacting veteran access to care since many SVHs are compelled to turn away new admissions due to their inability to recruit, hire, and retain sufficient staffing. NASVH has been grateful for VA's Nurse Recruitment and Retention Scholarship program which has had a positive impact on a number of SVHs. We are asking Congress to expand that program so that more Homes can benefit from it. At the same time, we believe that a similar program for other critical staffing vacancies – such as physical therapists, dieticians, social workers, etc. – could help boost the ability of SVHs to compete with private sector employers who are able to offer higher salaries and benefit packages. We hope to work with Congress to develop new and innovative programs that will help SVHs recruit and retain sufficient staffing to allow more veterans to be served by our Homes.

**OPPORTUNITIES TO EXPAND SERVICES AT STATE VETERANS HOMES**

Today, there are an estimated 8.3 million living veterans aged 65 or older, approximately 4.9 million who are 75 or older, and 1.3 million who are 85 or older. In total, the average daily census (ADC) for all VA-supported nursing home is only about 32,000 veterans; which is less than one-half of 1% of the approximately 8.3 million living veterans aged 65 or older, and just over 2% of those 85 plus; and VA projects these percentages to drop in future years.

Over the past decade, VA has been placing greater focus and resources on home- and community-based services (HCBS) and NASVH strongly supports expanding these services to provide aging veterans a full spectrum of long term care options. However, the amount of

nursing home care supported by VA today is woefully inadequate compared to the overall number of aging veterans. Although the need for nursing home care may diminish as the veteran population declines in future years, it will never go away; there will always be significant numbers of veterans who lack adequate family support to allow them to age at home. For these reasons, Congress and VA must continue to make smart investments to sustain and expand traditional bed-based care. VA should also expand home- and community-based care, but it should be an addition to, not a subtraction from facility-based care.

NASVH and our member State Veterans Homes will continue to seek new and innovative ways of delivering long term services to aging and ill veterans, including through a range of graduated care options for veterans who need support to age in place. SVHs understand aging veterans' needs and have expertise in connecting them with their VA benefits and services. With our clinical knowledge and extensive infrastructure, State Veterans Homes could serve as hubs in communities across the country, particularly in rural areas, to offer aging veterans a full spectrum of long term support services, including home-based care.

**Adult Day Health Care Programs**

In addition to skilled nursing and domiciliary care programs, SVHs are authorized to offer Adult Day Health Care (ADHC), which is a non-institutional alternative to a skilled nursing facility for aging veterans who have sufficient family support to remain in their own homes, but who need or will benefit from a day program that promotes wellness, health maintenance, and socialization. ADHC can help to maximize the participant's independence and enhance their quality of life, as well as provide much-needed respite for family caregivers.

To increase veterans' access to SVH ADHC programs, NASVH offers two recommendations. First, VA and Congress should modify and/or clarify current regulations so that the State Veterans Home Construction Grant program can be used to construct, modify, or expand SVH facilities to operate new ADHC programs. VA's current interpretation of federal regulations does not allow a SVH to apply for a construction grant in order to begin a new ADHC program; it may only seek a grant to expand or replace a facility being used currently for ADHC. Although dozens of states have expressed interest and taken steps towards offering adult day health care services, the single greatest barrier to entry is the construction of new or modification of existing space to properly operate an ADHC program. We call on Congress to work with VA to make this commonsense adjustment to encourage expansion of SVH ADHC programs.

Second, VA should authorize and take actions to encourage SVHs to establish satellite ADHC programs outside their facilities and campuses in more conveniently located areas where there are high concentrations of veterans who could use these services. For example, the Long Island State Veterans Home's ADHC program can only serve veterans in Suffolk County because of the distance they would have to travel. However, they have been working for several years to open a satellite ADHC program in neighboring Nassau County, which would open up this life-changing service as an option to thousands of additional veterans and their family caregivers.

**Additional Home-Based Care Services in State Veterans Homes**

In addition to expanding ADHC programs, NASVH also recommends that Congress and VA explore other ways for SVHs to develop new home-based programs, including ones similar to

VA's Home Based Primary Care, Homemaker Home Health Aide Care, Respite Care, Palliative Care and Skilled Home Health Care. For example, during the COVID pandemic, the Long Island State Veterans Home was forced to temporarily shut down its ADHC program under State orders intended to protect veterans. However, the Home was able to pivot to an innovative program that supported the veterans enrolled in its ADHC program by providing meals, PPE, telehealth, and home care visits. VA was able to support this temporary program using emergency powers granted to the Secretary during the pandemic.

Given the flexibility and financial benefits to VA from partnering with State Veterans Homes, there are myriad possibilities for better addressing the changing demographics, needs and preferences of veterans today and in the future. Many State Veterans Homes already offer a number of medical and therapeutic services that could be provided on an outpatient basis for veterans participating in home-based programs.

With our expertise on the needs of aging veterans, SVHs could develop an array of home-based services to support veterans who want to age in their own homes. When they are no longer able to remain at home, SVHs could ease their transitions to facility-based skilled nursing care. Such an integrated non-institutional program could begin as a pilot program, with different states customizing it to meet local circumstances. NASVH recommends that Congress consider establishing pilot programs to explore new arrangements for providing integrated home- and community-based programs through and in partnership with State Veterans Homes, offering a full spectrum of support from home care to skilled nursing care.

**Expanding the Spectrum of Care in State Veterans Homes via Assisted Living**

State Homes currently offer two levels of residential care: skilled nursing care for those who need significant support completing activities of daily living (ADLs) and domiciliary care, for those who are able to complete their ADLs, but require shelter, food, and other basic necessities. With millions of aging veterans no longer able to live independently, but whose needs fall in between these two levels of VA-supported care, NASVH believes it is time to begin offering assisted living programs in State Veterans Homes, which could offer greater support than offered by domiciliary care and would cost less than skilled nursing care.

NASVH was pleased that legislation we supported was included in the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* (P.L. 118-210) authorizing VA to create a pilot program to provide assisted living care for veterans. In particular, we appreciated the inclusion of a State Veterans Home in this pilot program, and we look forward to its swift and faithful implementation.

**Strengthening Mental Health Care for Aging Veterans in Nursing Homes**

Section 163 of Public Law 117-328, enacted in December 2022, required VA to create a new geriatric psychiatry pilot program at State Veterans Homes. Aging veterans with severe mental health and behavioral issues represent a challenge for both VA and SVHs due to the high level of supervision and intensive care required, particularly for veterans who pose a danger to themselves or others. The intention of this provision was to develop models of care for aging veterans with serious mental health issues which could be replicated at other SVHs to help care for this vulnerable population. Several states had indicated a willingness to move forward with

implementing this type of geriatric psychiatry program, including Louisiana, Washington, and West Virginia, if VA could provide some additional resources to support these programs.

Unfortunately, VA's implementation of this provision did not support the development of geriatric psychiatric programs at SVHs; instead, it offered a limited expansion of tele-mental health consultations through VA's Clinical Resource Hubs for SVH mental health clinicians who need additional expertise and advice. While this program may provide value to some Homes, it was not what was intended by the legislation, nor what is needed for this neglected segment of the aging veterans population. NASVH continues to believe that State Veterans Homes can play a larger role in addressing the mental health care needs of aging veterans, as this legislation intended, and would welcome the opportunity to work with the Subcommittee to reintroduce legislation that would do just that.

In fact, research has shown that many of the supports that State Homes provide to its aging veterans are protective factors for veterans in crisis and at risk of suicide. Further, veterans who connect with SVHs – whether in skilled nursing facilities, domiciliaries, or in adult day health care programs – are more likely to access other VA and state veterans services. For these reasons, expanding the scope of long-term care services offered by State Veterans Homes could play a small but meaningful part in VA's suicide prevention efforts.

**Conclusion**

Madame Chairwoman, State Veterans Homes can and must play a greater role in meeting the needs of aging veterans in partnership with VA and other federal agencies. NASVH looks forward to continuing to work with the Subcommittee to ensure that veterans who need long term care services can continue to receive safe, high-quality, and accessible care at State Veterans Homes. We would also welcome the opportunity to work with the Subcommittee to help expand aging veterans access to a full spectrum of long-term care options, whether at home or in nursing homes. That concludes my statement, and I would be pleased to answer any questions that you or Members of the Subcommittees may have.

**Prepared Statement of Charlton Meginley**

Louisiana Department of Veterans Affairs
State of Louisiana

JEFF LANDRY
GOVERNOR

CHARLTON J. MEGINLEY
SECRETARY

Statement of

**Colonel Charlton Meginley, Secretary**
**LOUISIANA DEPARTMENT OF VETERANS AFFAIRS (LDVA)**

Before the
**HVAC SUBCOMMITTEE ON HEALTH**

**APRIL 29, 2025**

Chairman, Ranking Member, and distinguished members of the HVAC Health Subcommittee thank you for the opportunity to testify today. On behalf of Governor Jeff Landry and the Louisiana Department of Veterans Affairs, I am proud to affirm our state's unwavering commitment to safely and effectively managing our five State Veterans Homes. These facilities are a cornerstone of our mission to provide exceptional care, dignity, and support to Louisiana's veterans. Through rigorous oversight, dedicated staff, and adherence to the highest health and safety standards, we ensure that our homes deliver compassionate, high-quality services tailored to the unique needs of our veteran residents. We look forward to discussing our ongoing efforts and addressing any questions you may have.

LDVA operates five State Veterans Homes supporting our 261,790 Veterans. Our Veteran Homes are strategically placed across Louisiana with facilities in Bossier City (NW Louisiana), Monroe (NE Louisiana) ((aligned to Shreveport VAMC)), Jackson (North of Baton Rouge), Reserve (SE Louisiana) ((aligned to New Orleans VAMC)) and Jennings (SW Louisiana) ((aligned to Alexandria VAMC)). Our current census as of April 14, 2025 is 641. FY '26's cumulative projective budget for the five homes is $102 million. Our occupancy rate amongst all five homes is 85%.

We currently have 580 men and 61 women residing in our homes. Under state law, Spouses and Gold Star families have access to our homes. Pending House Bill 60 in this current Louisiana

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legislative session, we aim to expand admission to National Guard members easing time in service requirements.

Additionally, each Home employs a Marketer who attends civic organization meetings, veteran service organization meetings, job fairs, and all community Veteran events to highlight our facilities. They distribute brochures and educational materials that showcase the benefits of our homes enabling us to realize continued growth in census.

Over the past 10-15 years, we've observed a shift from World War II to Vietnam veterans, with 67% of our residents now from the Vietnam era. We expect Vietnam veterans to remain the majority over the next decade, but after 2035, we anticipate a transition to predominantly Persian Gulf War veteran admissions.

**Louisiana State Veterans Homes: Demographics**

| | Vietnam | Peacetime | Korean | Spouses | Persian Gulf War | WWII | Totals |
|---|---|---|---|---|---|---|---|
| Bossier | 94 | 8 | 15 | 12 | 5 | 6 | 140 |
| Jackson | 67 | 10 | 10 | 2 | 5 | 0 | 94 |
| Jennings | 86 | 17 | 18 | 7 | 5 | 9 | 142 |
| Monroe | 81 | 22 | 6 | 2 | 9 | 4 | 124 |
| Reserve | 93 | 13 | 17 | 11 | 5 | 2 | 141 |
| Totals | 421 | 70 | 66 | 34 | 29 | 21 | 641 |

**Staffing**

Our department has worked closely with Louisiana State Civil Service, which oversees compensation for the state's classified workforce, to ensure our employees are paid at market rates. Over the past year, we have significantly raised starting salaries and premium pay for our nursing staff, leading to improved hiring and retention rates, reduced employee overtime, and decreased reliance on staffing agencies. This has allowed for the growth and stabilization of staffing over this past year. Further, we have updated each Veterans Homes' Rewards and Recognition policy to acknowledge employee accomplishments and show appreciation for their loyalty and dedication.

**Louisiana State Veteran Homes: Staffing**

| | Staff | Positions | Rate |
|---|---|---|---|
| Jennings | 147 | 153 | 96% |
| Bossier City | 137 | 150 | 91% |
| Monroe | 132 | 149 | 89% |
| Reserve | 133 | 151 | 88% |
| Jackson | 101 | 123 | 82% |
| Total | 650 | 726 | 90% |

**Veteran Home Oversight**

The Louisiana Department of Veterans Affairs manages our Veterans Homes under the oversight of the Federal VA and the Centers for Medicare and Medicaid Services (CMS). Each home is led by a licensed long-term care administrator actively engaged in daily operations. These five administrators report to our Deputy Assistant Secretary, a former SWLVH administrator with over 30 years of long-term care experience, who plays a pivotal role in guiding the homes. Additionally, COL (Ret) Jerome Buller, my Deputy Secretary and a 34-year Army Medicine veteran, serves as my corporate lead over our State Veteran Homes. A senior medical executive, Dr. Buller drives organization-wide process improvements by leveraging clinical, operational, and financial data, ensuring high-quality, safe, and effective patient care. He also serves as my key liaison with medical leaders within the three VA Medical Centers in Louisiana and the VA Central Office.

The department also employs two experienced, full-time Registered Nurses based at LDVA Headquarters who comprise our Compliance Team. This team works closely with the homes' leadership teams and Federal VA Liaison teams to ensure the Veterans receive the highest quality of care. The Compliance Team continuously evaluates all pertinent clinical data sources to ensure relevance and validity. It reports findings monthly to each facility and LDVA leadership team, draws accurate inferences based on data analysis, and presents recommendations for improvement or corrective action. They also organize, track, and trend clinical data regarding efficiency and effectiveness. Our team is directly involved in reviewing and approving the Homes Quality Assurance and Performance Improvement (QAPI) programs. The team visits each facility monthly to ensure operations run at the highest level. QAPI topics are selected in response to surveys, audits, and site visits and are closely monitored to help promote continuous process improvements. The Louisiana Quality Improvement Organization, Alliant Health Solutions, also provides QAPI topics in response to changing regulations. Our compliance team strives daily to promote strict adherence to both CMS and Federal VA long-

term care requirements and regulations, allowing us as an organization (LDVA) to further solidify our goal of ensuring the highest level of care for the veterans in our homes. This team also provides rapid response investigations to assist with clinical care inquiries.

Notable clinical achievements include reducing VA Survey deficiencies from 53 in 2023 to 34 in 2024, a 36% reduction. Additionally, no immediate jeopardy severity deficiencies have been reported for at least the past eight years. In 2025, our Reserve home received three deficiencies from their VA survey, a 57% decrease from their 2024 VA Survey which had seven deficiencies. Pressure Ulcer rates are at or below 5% system-wide, which is one-third that of the national average at over 15% in long-term care facilities; per the CMS Nursing Home Care Compare survey, three of our five facilities have earned 5-Star Ratings, and the other two have 4-Star Ratings, and all achieved while placing an intense focus on census building in response to the COVID pandemic!

The Federal VA significantly influences our facilities by overseeing key functions, including approving admissions (Forms 10-10SH and 10-10EZ), regulating basic per diem and service-connected funding, authorizing payments via Form 10-5588, coordinating specialty appointments for Veterans, conducting annual clinical and life safety surveys, approving corrective action plans post-survey, and reviewing reportable events such as issue briefs and sentinel events. Private Louisiana nursing homes are regulated by annual CMS/Louisiana Department of Health (LDH) clinical surveys, Fire Marshall Life Safety inspection, and Board of Health inspection of the facility. Our Veteran Homes regulatory surveys include these inspections private nursing homes receive, plus the annual VA clinical and life safety survey. In addition, the Louisiana Office of Risk Management performs a yearly safety inspection at each of our facilities, State Civil Service performs program audits of our Human Resources departments, and our Veterans Homes are subjected to performance and financial audits from the Louisiana Legislative Auditors office. Further, we have an Internal Audit Program that conducts department-wide audits with a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Internal Audit also coordinates all external audits conducted by state and federal regulatory and funding agencies, and is required to adhere to the Institute of Internal Auditors and International Standards for the Professional Practice of Internal Auditing.

**Best Practices**

Communication and Leadership relations lead our list of Best Practices. LDVA Secretary and Deputy Secretary are in regular contact with leadership from all three VAMCs, whether in person, by email, or by phone. We have open communications, which are mutually supportive with a forward-leaning approach. From the Veteran Home's perspective, this relationship blossoms when the VAMC appoints a single liaison (LNO) assigned to the homes in the VAMC

catchment area. With backup assigned, this single point of contact (POC) allows for home-specific, robust, and personal relationships with VAMC LNO and our homes' clinical leadership. Our LDVA Assistant Secretary for outreach is also closely connected with the outreach teams from all three VAMCs. Event attendance is mutually supportive, with rare exceptions. This has directly strengthened our state's response in addressing key issues like veteran homelessness and veteran suicide. Our Congressional leaders and other key stakeholders are updated on all significant events and occurrences that involve our Louisiana VAMCs. Leadership remains in constant communication with each National organizations (National Association of State Directors of Veterans Affairs (NASDVA) and National Association of State Veterans Homes (NASVH) and major veteran service organizations such as America Legion, Veterans of Foreign Wars, Disabled American Veterans, Vietnam Veterans of America, Military Order of the Purple Heart, etc.

Access to the VA's Computerized Patient Records System (CPRS) is another best practice. Clinical leadership at our Monroe facility has recently gained access to CPRS. It has proved very helpful in increasing the visibility of our residents' appointments and clinical management within the VA system, which has greatly enhanced their continuity of care. It has also improved the overall process flow with the management of specialty care appointments. Again, increased awareness of care provided within the VAMC ensures optimal case management of the veteran upon return to the veteran's home.

An additional best practice is the presence of a Veteran Assistant Counselor (VAC) in all of our facilities. Each of the 64 parishes in Louisiana has a VAC to assist Veterans with obtaining or increasing benefits. In the five parishes that house our Veteran Homes, the VAC dedicates 2 days a week to work at our facility to focus on reviewing DD214's in determining the eligibility of Veterans for admission, working closely with fiscal and social services departments following pending admits, filing claims for Aid and Attendance (A&A) pension to cover the cost of Care & Maintenance fees, education of veteran and family members of the availability of VA benefits and assisting Veterans with increasing service-connected disability ratings. Housing of the VAC in our State Veteran Homes gives our Veterans greater assistance with navigating the benefits process.

Finally, while not a best practice per se, our homes have an incredible relationship with the surrounding communities. Local elected officials, veteran service organizations, and religious and civic organizations are ardent supporters of our homes. On any given day at one of our homes, you will find the Knights of Columbus or Catholic War Veterans cooking jambalaya for the residents in Reserve or the VFW and American Legion holding their meetings with residents in Monroe. This past December, the U.S. Army football team visited our residents in Bossier City while they were in town for the Independence Bowl. Jennings regularly has various bands and

singers playing Cajun music, and Jackson has incredible support from our legislative teams. Make no mistake: our veteran homes feel like tiny military installations, a patriotic environment rich with esprit de corps and camaraderie, and less like standard nursing homes. Through committed leadership, dedicated clinical staff, and lessons learned, we have built an aggressive strategy driving clinical excellence to ensure our Veterans continue receiving high-quality, safe patient care in a compassionate and inclusive environment.

**Areas of Assistance Needed**

Federal reforms need to address the significant burden we face regarding high-cost medications. The VA requires State Veteran Homes to cover the cost of all medicines if the Veteran is 70% service connected or greater. As of 1 April 2025, we have 216 (34%) residents rated 70% or higher. This is significant because, currently, the VA does not provide relief for the cost of exceptionally expensive medications except for those "catastrophically injured." This is concerning, given the progression in the development of new key medications that are exceptionally expensive. The pharmaceutical cost of 34% of our residents, those who are service-connected, is $1,064.450.85. This represents 65% of the total pharmaceutical cost for all five homes, which is $1,628,330.49.

One story to share is about a service-connected Veteran in our NWLVH in Bossier City in October of 2023 who developed Huntington's disease. The doctor ordered Austedo XR, which cost approximately $10,000 per month, but there was no determination of how long the veteran would need to receive medication. After expressing our concerns, the doctor researched and found Ingrezza to be effective and lower the cost to just over $7,000.00, which still consumed most of the Veteran's monthly per diem.

Our department strongly supports HR 1970, "Providing Veterans Essential Medications Act." This is an important amendment to Title 38, USC, directing the Secretary of VA to reimburse State Veteran Homes for the cost of or furnish State Homes with certain costly medications provided to veterans who receive nursing home care in such state homes.

LDVA would also like to see greater support for our veterans' Mental and Behavioral Health. We have observed a rise in the acuity level of care and an increase in diagnoses of mental health and behavioral issues, such as PTSD and TBI, among Vietnam and Korean War-era veterans. The VA offers very limited options for care in Veterans with violent or combative behaviors, yet SVHs are expected to help serve this population. There is a growing nationwide shortage of mental health beds, and even more so in the vulnerable Veteran population we serve. In a recent survey of our homes over a 2-year span, there were 134 episodes of a

Veteran transferring to a behavioral/psychiatric facility for treatment. During this same period, 72% of our facility admission denials were due to behavioral health issues, and we were not adequately equipped to care for them. Currently, in our Louisiana State Veteran Homes, 58.4% (Range: 38-85%) of our residents have multiple mental health diagnoses, 45.7% (Range: 40.6 – 53.2%) have Dementia or Alzheimer's, and 26.9% (Range: 22.3-36.2%) are on antipsychotic medications. Our Louisiana State Veteran Homes are not equipped to care for psychiatric/behavioral health residents in the acute phase. Subsequently, these residents are referred out of LDVA care to private geriatric psychiatric facilities. We recently had to turn away a 100% rated veteran because we did not have the capability to manage his acute mental health care adequately.

Community facilities do not treat the underlying cause of acute psychiatric or behavioral health issues. They treat symptoms and behaviors with high doses of antipsychotic medication and sedatives and return residents to the LDVA facilities. There is no emphasis on follow-up and prevention of subsequent psychiatric exacerbations (a revolving door of sorts). The Behavioral Health model we feel would best suit the mental health needs of our Veterans is one that is centrally located geographically, run by qualified mental health providers, and allows access for current LDVA residents and those veterans in the communities that have referrals and need acute mental health treatment with continuity of care. Expansion of inpatient behavioral health beds at VAMCs would be highly desirable to help with continuity of care. Of note, in 2023, Alexandria, VAMC, reopened seven inpatient beds for veterans requiring inpatient management of substance use disorders. While this helps, it does not meet current demand.

Louisiana also joined two other states in volunteering for the Geriatric-Psychiatry pilot study to assess optimal staffing and infrastructure requirements to offer a more robust, holistic in-home Geriatric-Psychiatry capability. We were very disappointed when we learned that this pilot was halted. We strongly recommend proceeding with such a pilot. Once again, Louisiana would love to lead the effort, and we would specifically propose adding a psychiatric wing in our Jackson home.

Finally, the Jackson facility is our oldest building, at 43 years old, while our homes range from 18 to 43 years old. We are directly involved with facility management and have successfully maintained our homes; however, additional funding will be needed for repairs and renovations for all homes. We strongly recommend adequately funding the VA's State Veteran Homes Construction Grant Program to address the current backlog and meet future demand.

**Conclusion**

In conclusion, our veterans have sacrificed immensely for our nation, and it is our duty to ensure their well-being and support. LDVA leadership will continue to work closely with our VA partners to ensure clinical quality and patient safety in our State Veterans Homes, which remain a priority. Addressing the high costs of essential medications and enhancing mental and behavioral health services are critical steps in honoring the service and commitment of our Louisiana veterans. We urge Congress to take swift action on HR 1970 and to support any initiatives that will improve the quality of care and life for our veterans. By working together, we can ensure the continued delivery of comprehensive, respectful, and dignified care that our veterans deserve. Thank you for your attention and dedication to these critical issues.

## Prepared Statement of Florida Department of Veterans Affairs

We operate nine State veterans' homes in Florida with a total of 1,102 beds. Eight are skilled nursing facilities and one is a domiciliary offering assisted living. Florida's State Veterans' Nursing Homes are among the top nursing homes in the State.

The relationship between the VA and Florida is good; however, the VA long-term care system has historically struggled to keep up with current national long-term care models. Highlighting home and community-based care should be encouraged. We recommend VA support States and Territories that desire to integrate a long-term care campus that allows them to offer additional services to Veterans to remain in their homes in the community.

We recommend changing the static model of traditional nursing home beds to one that provides Veterans with a more robust venue of long-term care services. Florida is planning a 120-bed State Veterans' Nursing Home that includes adjoining Adult Health Day Care, outpatient rehabilitation services and a community wellness center for local Veterans. We feel the decades-old model for strictly long-term care beds is restrictive and does not reflect the needs of today's aging Veteran. Additionally, our proposed model will allow Veterans to access health care services while providing an avenue for camaraderie that can improve their health outcomes.

Previous attempts to provide these updated services in existing State Veterans' Home sites have been denied by the VA, citing 20-year moratoriums imposed on original construction grants designed solely for long-term care beds. The denial is based on VA's interpretation of 38 CFR § 59.110.

Providing enhanced services to local Veterans in areas with a small VA footprint saves travel time and keeps Veterans in their homes, allowing much-needed respite care for their family members and caregivers. The added socialization combats isolation and conversely helps combat veteran suicide.

VA's State Veteran Home Construction Grant Program should reflect these new national models of long-term care as States seek to expand their services for Veterans. We also recommend an overall increase in funding for the State Veteran Home Construction Grant Program to combat a backlog of vital projects. Previous years funding has made only a small dent in expanding and enhancing long-term care services for our Veterans. Many needed construction and rehabilitation efforts are delayed by years due to inadequate funding. According to the VA, the State of Florida is currently short of more than 2,900 Veterans' Nursing Home beds. At the current rate of funding, it would take decades to fill the gap. We be-

lieve increased funding, coupled with access to non-institutional long-term care, can provide a bridge for our aging Veterans' long-term care needs.

In Florida, it costs nearly twice the reimbursement rate provided by VA to pay for care of Veterans in our 150-bed Domiciliary home. We recommend VA review their compensation rates for long-term care, as reimbursements to States for Veterans in Veterans' Domiciliary Homes vastly understate the true cost of healthcare.

We appreciate the opportunity to provide testimony and continue our collaborative work with the VA to enhance care for our Nation's Veterans.

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**Prepared Statement of Veterans of Foreign Wars of the United States**

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our comments on this important topic.

As the United States veteran population ages, the demand for long-term care will increasingly represent a significant portion of the Department of Veterans Affairs (VA) health care. Long-term care includes various services to address a veteran's health or personal care needs when the individual can no longer perform daily activities unassisted. VA offers care through nursing homes, assisted living, home health care, and State Veterans Homes (SVHs). SVHs are nursing facilities, assisted living facilities, or domiciliary care homes operated by State governments specifically for veterans. They provide long-term care services customized to address the unique needs of veterans. There are many benefits to SVHs, such as subsidized care, VA per diem grants that lower out-of-pocket expenses, and a supportive environment to connect with fellow veterans and build camaraderie. VA provides general oversight to all 153 SVHs, which collectively care for approximately 14,500 veterans.

**Background**

State Veterans Homes trace their origins back to the pre-Civil War era, designed initially to care for injured and aging soldiers. These facilities were commonly referred to as soldiers' homes. In 1888, Congress authorized Federal funding to support state-operated veterans' homes, establishing a partnership between State and Federal Governments that continues today. VA provides per diem payments for each veteran receiving care in these homes. It is another way to assist the veteran in cutting out-of-pocket costs. VA also provides construction grants covering up to 65 percent of building or renovation costs of SVHs. States are required to provide at least 35 percent in matching funds. To qualify for VA funding, SVHs must adhere to VA quality standards in areas such as quality of care, standard of living, infection control, and resident rights.

All 50 states and Puerto Rico either have at least one SVH or have been approved to build one, and some states have multiple homes due to population size or geographic distribution. Examples of State agencies that oversee SVHs include the California Department of Veterans Affairs (CalVet), the Texas Veterans Land Board, the New York State Division of Veterans' Services, and the Florida Department of Veterans Affairs. SVHs typically offer services, including skilled nursing care, assisted living for independent veterans needing support, memory care units, and short-term rehabilitation or post-acute care. Eligibility criteria for SVHs generally require service in the U.S. Armed Forces with an honorable discharge, residency in the State, and medical or personal care needs that align with the services provided.

**Needs of the Aging Veteran**

Aging veterans are unique individuals shaped by their military experiences, natural aging processes, and socioeconomic circumstances. Many elderly veterans face multiple chronic conditions and may have health issues related to their service, which can lead to the need for assisted living or nursing care. They may encounter

various challenges, including limited income, transportation barriers, social isolation, difficulty accessing benefits, and cognitive decline.

Essential services for aging veterans include geriatric primary care, mental health support, neurology and memory care, rehabilitation and physical therapy, and dental and vision care. For veterans who can no longer live independently, a skilled nursing facility may be the best option, particularly if they are unable to perform activities of daily living or require supervision due to vulnerability. Loneliness and a diminished sense of worth often become more pronounced as they age. The camaraderie once enjoyed may be a distant memory, overshadowed by declining health and the loss of family and friends. All of these factors can contribute to higher risks for suicide among aging veterans.

A coordinated, veteran-centered approach is necessary to effectively meet the needs of aging veterans and address their overall well-being. This approach should include medical and mental health care, housing, social connections, and the dignity that should be afforded to them. Delivering comprehensive care including geriatric-specific services, and integrated mental and behavioral health support, is critical for enhancing the quality of life for these individuals.

**SVH Oversight**

State governments and VA collaborate to provide SVHs as an option for veterans. VA is responsible for providing per diem for eligible veterans, and construction grants for building and renovating facilities. Unfortunately, there is a massive $1.2 billion backlog in construction needs of SVHs, which potentially places some veterans in unsafe living conditions and others waiting for available facilities.

VA's Geriatrics and Extended Care program oversees the per diem funding and ensures compliance with VA standards. These standards include maintaining quality of care, adequate staffing levels, timely recordkeeping, and safe, sanitary living conditions. VA conducts regular inspections, and homes that do not meet these standards are cited for deficiencies. According to a November 2022 Government Accountability Office (GAO) report, *VA Nursing Home Care: Opportunities Exist to Enhance Oversight of State Veterans Homes*, deficiencies increased from 424 in 2019 to 766 in 2021. This included a 12 percent rise in deficiencies that resulted in actual harm or immediate jeopardy. Additionally, data from 2020 was missing from this report as VA suspended inspections during the COVID–19 pandemic, precisely when inspections were most critical. The report also found that an outdated data system led to insufficient analysis of SVH data, and current plans for a replacement data system would not guarantee that VA would have the necessary analytical capabilities to improve efficiency. GAO recommended that VA identify additional enforcement tools and seek legislative authority to strengthen its oversight capabilities.

VA published a policy notice in August 2024 on oversight requirements for SVHs that provide nursing home care, domiciliary care, and adult day health care. This notice detailed the administration, oversight, and certification processes for Recognition, Annual, and For-Cause Surveys of SVHs, explicitly focusing on compliance with Federal regulations. Key elements include the survey processes, corrective action plans for addressing noncompliance, and the roles of various VA personnel in managing and overseeing SVH operations. The goal is to ensure eligible veterans receive high-quality care in a safe environment while VA maintains proper oversight of the SVHs.

**VFW Concerns**

VFW members have raised concerns about long waitlists for admission to SVHs due to the limited number of facilities and available beds. The quality of care at SVHs is generally good, though veterans have had issues with slow communication and responses concerning inquiries about patient care, billing issues, eligibility, and space availability for individuals waiting to be transferred from medical hospitals. These delays create significant stress for veterans and their families.

For example, one Missouri veteran had been waiting so long for placement in an SVH that VA moved him to a nursing home with a low standard of care. He also experienced poor communication from the staff while he waited for a bed to become available at an SVH.

Veterans have told the VFW they have concerns about the lack of clear communication and setting expectations during the eligibility, application, and waitlist processes. The perception exists that if a veteran or that person's caregiver contacts a civilian nursing home, the veteran could likely secure a bed within a few days. However, delays in access and availability are prevalent at SVHs due to the limited number of facilities and a lack of beds required to meet the current demand.

Veterans in Alabama have voiced concerns about obtaining information regarding eligibility criteria for SVHs. They are particularly troubled by the significant vari-

ation in eligibility requirements and processes, even among specific facilities within the same state.

Maryland veterans and their families have reported multiple concerns including the lengthy application process and waitlists for admission to SVHs and lack of communication during this time, insufficient communication with survivors regarding billing issues and difficulties obtaining documentation even after payment has been made, and challenges in processing new patients during periods of system upgrades and changes in contracts. When veterans and their families raise concerns about living conditions at SVHs, VA should be responsive and address these issues effectively since it funds a significant portion of these services.

It is time for VA to proactively address the concerns of the aging veteran population. VA can enhance compliance with quality standards by developing a range of enforcement options to correct deficiencies identified during inspections. Additionally, VA needs to establish a process for monitoring the implementation of corrective action plans, enabling it to track how care facilities address noncompliance issues. It is also crucial for VA to improve its ability to set and manage expectations for medical or care facilities that serve our veterans, while communicating those expectations to their families.

The VFW urges Congress to provide full funding for VA to address the backlog of pending State Home Construction Grants. This would address the growing need and ensure these facilities are safe for veterans. We also urge Congress to provide oversight of VA's surveys and monitoring of SVHs to ensure high-quality standards for our Nation's veterans.

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my statement. Thank you for the opportunity to offer our comments on this important issue.

**Information Required by Rule XI2(g)(4) of the House of Representatives**

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any Federal grants in Fiscal Year 2025, nor has it received any Federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

**Prepared Statement of The National Association of State Directors of Veterans Affairs, Inc.**

***The National Association of State Directors of Veterans Affairs, Inc.***

April 21, 2025

***State for the Record*** for HVAC Subcommittee on Health hearing April 29, 2025.

The State Veterans Home (SVH) Program represents the largest and most cost-effective partnership between the federal and state governments for veterans. SVHs provide over 50% of the total VA long-term care across all 50 states and the Commonwealth of Puerto Rico, operating through **171 SVHs**. These homes offer essential services to elderly and disabled veterans, providing more than 30,000 authorized beds for skilled nursing care, domiciliary care, and adult day health care.

NASDVA and the NASVH (National Association of State Veterans Homes) share a strong, collaborative working relationship. Both NASDVA and NASVH are committed to significantly funding the VA's State Veterans Home Construction Grant Program. This program is the largest grant initiative between the Federal and State VAs. The VA provides up to 65% of construction, rehabilitation, and repair costs, while states are required to provide at least 35% in matching funds. The FY2024 Priority List includes 81 Priority Group 1 projects where states have already secured matching funds, necessitating a federal share of approximately $1.3 billion, which represents an increase of about 30% over the previous fiscal year. The FY2024 appropriation of $171 million was sufficient for only nine projects. The VA's FY 2025 appropriation for State Veterans Home Grants is projected to be just $147 million. The demand for long-term care services among veterans is rising. An estimated 8.4 million living veterans are 65 years or older, including approximately 2.6 million who are 80 years or older and 1.3 million who are 85 years or older. Therefore, it is crucial for our nation's senior veterans to maintain the existing backlog of projects in the Grant Program at a manageable level to ensure life safety upgrades and new construction. To address the growing need and backlog, and to fund at least half of the pending Priority Group 1 grant requests, Congress should allocate at least **$650 million**.

NASDVA also has concerns about behavioral health and future incidences of PTSD, TBI, and other conditions in the aging Veteran population. While there are war-related traumas that lead to PTSD in younger OEF/OIF Veterans, aging Veterans can be exposed to various catastrophic events and late-life traumas that may cause the onset of PTSD or trigger the reactivation of pre-existing PTSD. PTSD has been observed more frequently in recent years among World War II, Korean, and Vietnam War Veterans and has proven difficult to manage. The VA offers limited care for Veterans with a propensity for combative or violent behavior, and the community expects the VA or SVHs to serve this population. NASDVA and NASVH recommend a new Grant Per Diem scale that reflects the staffing intensity required for psychiatric beds and medication management. SVHs and VA Community Living Centers are unable to serve intensive care psychiatric patients; therefore, the VA cannot allocate hospital psychiatric beds due to a lack of community psychiatric step-down capacity. This level of care is

critically needed in our states. The VA is responsible for specialty care for Veterans in SVHs, particularly when the care is in response to a service-connected condition. Often, when coverage requires specialized healthcare services such as psychiatric care, the VA does not cover the cost. Psychiatric services are outside the scope of primary care provided to SVH residents; however, they should be treated as allowed specialty care, similar to cardiology and urology.

The nationwide shortage of direct-care providers, including doctors, RNs, LPNs, and Certified Nursing Assistants, is well-documented. COVID-19 exacerbated the decades-long decline as fewer healthcare professionals are recruited, while many providers are leaving the workforce or retiring in large numbers. The national competition for providers is also creating an untenable situation, further worsened by burnout among nursing professionals due to the rigors of care and the salaries offered by large, well-financed hospital groups. Maintaining the SVH resident census is challenging because of chronic staff shortages, which result in fewer Veterans being served and providers struggling to cope with financial losses caused by lower reimbursement rates linked to a reduced resident census. Vulnerable Veterans in need of care are being denied access due to insufficient staffing to meet the demand. SVHs appreciate VA's *Nurse Recruitment and Retention Grant Program*, which promotes the hiring and retention of nurses. It has been effective. However, this applies only to the positions of RNs, LPNs, Licensed Vocational Nurses, and Certified Nursing Assistants. Expanding the grant program should include other critical staffing roles, such as Physicians, Physical Therapists, Dieticians, and Social Workers. This expansion would help SVHs compete with private sector facilities that offer sign-on bonuses, higher salaries, and better benefits. SDVA and VA must continue their recruitment and retention efforts to ensure the quality and quantity of providers needed to care for eligible Veterans.

VA is authorized to cover up to 50% of the cost of care through per diem for residents receiving care in an SVH. However, the current basic rates cover less than one-third of the costs. Many factors, including competitive labor costs, higher pharmaceutical expenses, rising food prices, unfunded mandates, and overall medical inflation, have diminished the value of per diem. Honorably discharged Veterans are eligible for a daily VA per diem payment. The FY2024 rates are as follows: Nursing Care $144.10 per veteran, per day; Adult Day Healthcare $114.81 per veteran, per visit; and Domiciliary Care $62.20 per veteran, per day. Both NASDVA and NASVH recommend a new Grant Per Diem scale; thus, the rates need to be increased. Veterans with a service-connected disability of 70% or higher are eligible for no-cost nursing care at the SVH; however, the VA does not cover high-cost medications for this cohort. Certain medications, such as chemotherapy and biologicals, can cost thousands of dollars per month. Community contract nursing homes with the VA are reimbursed when these costs exceed a certain percentage (typically 8.5%) of the per diem. Congress needs to legislate that SVHs receive the same reimbursement as addressed in *H.R.1970 – Providing Veterans Essential Medications Act.*

VA's ***Geriatrics and Gerontology Advisory Committee*** was established to advise the Secretary of VA on all matters related to geriatrics and gerontology. It is our understanding that the committee has been suspended. This committee was positioned to offer recommendations on the procedures and policies governing SVHs. If the committee is reinstated, it would be appropriate for it to include a voting member who is a licensed nursing home administrator

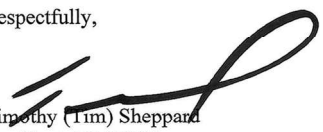
currently serving as an SVH administrator or supervising an SVH, which would benefit the committee.

Oral health issues have a direct connection to overall physical and mental health. The VA offers comprehensive dental care benefits to over 600,000 qualifying Veterans, and their dental issues must be directly related to their military service to be eligible. Many residents in SVH do not qualify. A veteran is generally required to have a service-connected dental disability, be rated as 100% disabled due to other service-related conditions, or be a former Prisoner of War. Veterans who do not meet the eligibility criteria must seek oral health care outside of SVH. For many, this is difficult due to out-of-pocket expenses, travel distances, their physical condition, or a lack of dentists in the community near the SVH. Maintaining good oral health can lead to a reduction in heart disease. Presumptive conditions, such as diabetes from Agent Orange exposure, can also negatively impact oral health. Veterans struggling with mental health challenges may neglect daily tasks like brushing their teeth and may even experience dry mouth from the medications they are taking. These compounding issues may cost the VA healthcare system more money because they then become secondary ailments to the initial mental health disorder. NASDVA supports efforts to expand the eligible pool of Veterans entitled to dental care services through the VA to include SVH residents, which may, in turn, reduce other healthcare challenges associated with poor oral care.

SVHs are subject to duplicate inspections. The VA performs an annual survey that reviews clinical practices and life safety protocols while also conducting a financial audit. Furthermore, many SVHs are certified by CMS to qualify for CMS reimbursements, which requires them to undergo a separate CMS inspection. The VA and CMS surveys are identical in their examination of the clinical and life safety sections. NASDVA and NASVH recommend that SVHs undergo a single annual survey conducted by the VA, which should be acceptable to CMS.

We respect the HVAC Subcommittee on Health's operational oversight and funding input for the State Veterans Homes. Your understanding and support of this vital service to our nation's patriots are important. Thank you for the opportunity to submit this Statement for the Record.

Respectfully,



Timothy (Tim) Sheppard
President, NASDVA
Director, Wyoming Veterans Commission

**Prepared Statement of Sheri Biggs**

## Statement for the Record

Submitted by Representative Sheri Biggs, U.S. House of Representatives
Lieutenant Colonel, United States Air National Guard
Board-Certified Family and Psychiatric Mental Health Nurse Practitioner
Former Administrator, State-Run Veterans Nursing Home

Before the House Committee on Veterans' Affairs, Subcommittee on Health
"Dignity Denied: The Case for Reform at State Veterans Homes"
April 30, 2025

Chairwoman Miller-Meeks and Members of the Subcommittee: It is an honor to submit this Statement for the Record. My name is Representative Sheri Biggs. I bring three decades of experience in clinical and administrative roles serving veterans and other vulnerable populations. My professional background includes work as a dual board-certified nurse practitioner in family practice and psychiatric mental health, a Air National Guard Lieutenant Colonel, and an administrator and consultant of a state-run veterans' homes. These experiences have shaped my understanding of the structural, clinical, and ethical demands required to care for aging veterans. In both my clinical and community roles, I have personally worked with many veterans grappling with suicidal ideation and untreated mental health conditions. Tragically, in my district alone, eight veterans have died by suicide this year.

This testimony addresses the urgent need for modernized federal-state oversight and support mechanisms for State Veterans Homes (SVHs), which serve as the long-term care backbone for many aging veterans. Despite substantial VA investments and detailed federal policy frameworks, significant operational discrepancies continue to jeopardize veteran safety and undermine public trust.

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**Elderly Veterans Require a Standard of Care Consistent with Their Sacrifice**

Veterans aging into long-term care often present with complex behavioral health profiles, including high rates of depression, anxiety, PTSD, dementia, and substance use disorders. According to VA's own figures, roughly half of veterans in long-term care settings carry at least one mental health diagnosis (VA OIG, 2024).

My work and writing in the veteran mental health space have emphasized that post-traumatic stress is not only an individual condition—it is a family condition. In my recent article, *"No Greater Love: PTSD's Impact on Spouse, Family of Veteran,"* I outlined how trauma from combat deployment reverberates through the veteran's home life. PTSD has been shown to directly contribute to relationship dysfunction, communication breakdowns, and mental strain on spouses and caregivers. Once it

enters a household, only 3 in 10 military marriages survive long-term. These family dynamics follow our veterans into long-term care, where social withdrawal, unresolved trauma, and deteriorating family ties make treatment and recovery even more complex. If our system continues to isolate mental health treatment from the broader social environment veterans live in, we will continue to miss key risk indicators and opportunities for support (Biggs, 2023).

GAO's testimony highlighted that more than 40% of veterans in state homes received the same deficiency citation two years in a row, signaling persistent noncompliance in critical areas like infection control and suicide risk screening (GAO-25-108441). While VA conducts annual unannounced inspections across 200 clinical and safety standards, its enforcement tools remain limited. Unlike CMS, VA has no moderate enforcement options—its only penalty is withholding per diem payments, a measure it has never used due to its severity.

The 2018 University of Michigan and RAND Corporation study adds further urgency, showing veterans relying solely on private-sector mental health care face significantly higher suicide risk than those receiving care through the VA system (Smith et al., 2021). Given that SVHs operate at the junction of state and federal systems, it is unacceptable that we do not have seamless VA clinical integration, preventive protocols, or adequate behavioral health resources.

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**Enhancing Oversight Through Practical, Targeted Reform**

Congress should act to ensure VA identifies a continuum of enforcement tools—including partial per diem suspensions or corrective action timelines—to enforce compliance without resorting to extreme measures. As GAO has noted, VA walked back its 2023 plan to seek such authority and instead relies on enhanced follow-up, which does not compel compliance (GAO-25-108441).

State-level data from Louisiana underscores the need for reform: 58% of SVH residents there have multiple mental health diagnoses, and nearly 27% are prescribed antipsychotics. Yet homes routinely deny admissions due to insufficient psychiatric support. Over a two-year period, Louisiana's five SVHs logged 134 behavioral health transfers and denied 72% of admissions on mental health grounds (LDVA, 2025). We cannot continue to turn away veterans at their moment of greatest need due to structural incapacity.

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**Enabling Data-Driven Coordination and Transparency**

Oversight should be rooted in quality outcomes. While VA tracks clinical metrics across SVHs, those data are not uniformly shared with facilities, nor integrated into real-time decision-making platforms. Louisiana's best practice of embedding VA liaisons

and granting CPRS access to SVH staff illustrates how visibility into clinical records can enhance care coordination (LDVA, 2025).

Facilities need secure access to suicide risk flags, discharge plans, and behavioral safety protocols. Absent that, SVHs operate with blind spots that endanger patients.

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**Conclusion**

The testimony provided by VA, GAO, and state administrators today paints a clear picture: our current oversight structure is fragmented, outdated, and insufficiently resourced to meet the needs of an aging veteran population with complex mental health needs.

State Veterans Homes should not be left to navigate these challenges in isolation. They require partnership—true partnership—with the VA. That means better data access, smart oversight, and the clinical integration that veterans deserve.

It is my hope that this hearing marks a shift from rhetorical concern to meaningful reform.

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**References:**

VA Office of Inspector General (OIG), *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, December 18, 2024.

GAO, *VA Nursing Home Care: Opportunities Remain to Enhance Oversight of State Veterans Homes*, GAO-25-108441, April 29, 2025.

Statement of Ed Harries, President, National Association of State Veterans Homes, April 29, 2025.

Statement of Charlton Meginley, Secretary, Louisiana Department of Veterans Affairs, April 29, 2025.

Smith, G. et al., *Veteran Access to Mental Health Care and Suicide Risk*, RAND Corporation and University of Michigan, 2018.

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## Questions for the Record Submitted by Mariannette Miller-Meeks

**Questions for the Record**

House Committee on Veterans' Affairs
Subcommittee on Health
"*Dignity Denied: The Case for Reform at State Veterans Homes*"
April 29, 2025

**Questions for Dr. Scotte R. Hartronft, M.D., Executive Director, V.A. Office of Geriatrics & Extended Care, Veterans Health Administration, U.S. Department of Veterans Affairs (V.A.)**

**Chairwoman Mariannette Miller-Meeks (IA)**

1. We recently learned that residents had to evacuate a state veterans home in Enterprise, Alabama, because of a kitchen fire. I am grateful no one was harmed. What is the status of the relocated veterans? Does V.A.'s annual audit include requirements for protocol when residents and staff need to evacuate in times of emergency?
2. Does staffing retention at state veterans homes follow the same trends as staffing retention at V.A. health care facilities? What are notable differences, if any?
3. A November 2022 report by the U.S. Government Accountability Office (GAO) found that between July and September 2022, V.A. completed 69 percent of annual state veterans homes inspections in-person, and 31 percent virtually. What is the percentage of in-person inspections for 2024?
4. A state veterans home in Holyoke, Massachusetts, saw at least 76 veteran deaths and over 160 infections during a COVID-19 outbreak in Spring 2020. Please provide a copy of V.A.'s corrective action plan for this home for the applicable time period the year before the outbreak, the year during the outbreak, and the year following the outbreak.
5. As indicated in the statement by GAO, V.A. provided evidence of a plan for improving its data system used to analyze state veterans home survey data. Please provide a copy of this plan. Has V.A. implemented the plan yet? What is its status?
6. As GAO's statement indicated, V.A. has implemented a process to follow up with homes soon after deadlines passed with corrective action plans. Has V.A. continued to use this process? How many homes currently have unresolved deficiencies past the due date indicated in the corrective action plan? Are any of these deficiencies rated as causing actual harm or immediate jeopardy?

**Questions for the Record**

House Committee on Veterans' Affairs
Subcommittee on Health
"*Dignity Denied: The Case for Reform at State Veterans Homes*"
April 29, 2025

**Questions for Ms. Sharon Silas, Director, Healthcare, U.S. Government Accountability Office (GAO)**

**Chairwoman Mariannette Miller-Meeks (IA)**

1. What is the importance of U.S. Department of Veterans Affairs' (V.A.) oversight in state veterans homes?
2. It has been observed that COVID-19 was devastating for all, but that there were acute issues in some state veterans homes. What did GAO observe of V.A.'s oversight during the pandemic?
3. The state veterans home program falls under V.A.'s Office of Geriatric and Extended Care (GEC). What has GAO observed of GEC's oversight, and does GAO recommend greater GEC-led involvement so that V.A. can meet GAO's recommendations?
4. What are GAO's recommendations to improve how V.A. collects and analyzes data from annual inspections? Are those recommendations implemented?

**Questions for the Record**

House Committee on Veterans' Affairs
Subcommittee on Health
"*Dignity Denied: The Case for Reform at State Veterans Homes*"
April 29, 2025

**Questions for Mr. Ed Harries, President, National Association of State Veterans Homes**

**Chairwoman Mariannette Miller-Meeks (IA)**

1. What challenges do states typically encounter when trying to initiate construction for a state veterans home using grant money from V.A.?
2. Please describe challenges and best practices you have observed for staff recruitment and retention in state veterans homes.

**Questions for the Record**

House Committee on Veterans' Affairs
Subcommittee on Health
"*Dignity Denied: The Case for Reform at State Veterans Homes*"
April 29, 2025

**Questions for The Honorable Charlton J. Meginley, Col (Ret), USAF, Secretary, Louisiana Department of Veterans Affairs**

**Chairwoman Mariannette Miller-Meeks (IA)**

1. The Committee has heard that delays in the federal government make it difficult for states to match federal funding for construction projects. Has this been the experience of the Louisiana Department of Veterans Affairs?
2. How do veterans homes prepare for emergency weather events in Louisiana?