



## Testimony

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

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For Release on Delivery  
Expected at 10:00 a.m. ET  
Wednesday, July 29, 2020

# VA HEALTH CARE

## VA Needs to Continue to Strengthen Its Oversight of Quality of State Veterans Homes

Statement of Sharon M. Silas, Director, Health Care

# GAO Highlights

Highlights of [GAO-20-697T](#), a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

Veterans—like over a million other Americans—rely on nursing home care to help meet their health needs. For eligible veterans whose health needs require skilled nursing and personal care, VA provides or pays for nursing home care in three nursing home settings: the VA-owned and -operated community living centers, public- or privately owned community nursing homes, and state-owned and -operated SVHs. In fiscal year 2019, VA provided or paid for nursing home care for over 39,000 veterans. The majority of these veterans received care at SVHs.

This statement summarizes the GAO's July 2019 report, [GAO-19-428](#), with a focus on issues related to SVHs. Specifically, it describes the: (1) use of and expenditures for SVHs, (2) inspections used by VA to assess the quality of SVH care and VA's oversight of the inspection process, and (3) information VA provides publicly on the quality of SVH care. As part of that work GAO analyzed VA data on expenditures for SVHs and interviewed VA officials. For this statement GAO reviewed expenditure and utilization data for fiscal year 2019.

## What GAO Recommends

In its July 2019 report, GAO made three recommendations related to SVHs, including that VA require that all failures to meet quality standards are cited as deficiencies on SVH inspections. VA concurred with two recommendations and concurred in principle with the third. VA has addressed one recommendation and continued attention is needed to address the two remaining recommendations.

View [GAO-20-697T](#). For more information, contact Sharon M. Silas at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov).

July 29, 2020

## VA HEALTH CARE

### VA Needs to Continue to Strengthen Its Oversight of Quality of State Veterans Homes

#### What GAO Found

The Department of Veterans Affairs (VA) pays over \$1 billion a year to state veterans homes (SVH)—homes owned and operated by the states—to provide nursing home care to approximately 20,000 veterans. In fiscal year 2019, VA paid SVHs \$1.17 billion for an average daily census of 20,072 veterans (51 percent of the total veterans receiving nursing home care through VA). Further, VA projects its payments to SVHs will continue to increase; VA projects it will pay \$1.7 billion to SVHs to provide care to veterans in fiscal year 2022.

VA oversees the quality of care veterans receive at SVHs mainly through annual inspections that VA hires a contractor to perform. In its July 2019 report, GAO found that VA's SVH contractor performed the required annual inspections for all SVHs in 2018, but VA needed to take action to enhance its oversight of SVHs and to ensure that information on quality of care provided in this setting is publicly available to veterans. Specifically, GAO found the following:

- **VA does not require its SVH contractor to identify all failures to meet quality standards during its inspections as deficiencies.** For example, GAO found that VA allows its SVH contractor to cite some failures to meet quality standards as “recommendations,” rather than as deficiencies. VA officials said they do not track or monitor the nature of the recommendations or whether they have been addressed. As a result, VA does not have complete information on all failures to meet quality standards at SVHs and cannot track this information to identify trends in quality across these homes.
- **VA is not conducting all monitoring of its SVH contractor.** GAO found that, at the time of its review, VA had not monitored the SVH contractor's performance of inspections through regular observational assessments to ensure that contractor staff effectively determine whether SVHs are meeting required standards. Specifically, VA officials said they intended to observe the SVH contractor's inspections on a quarterly basis; however, at the time of GAO's review, VA officials could not recall when VA last observed the SVH contractor's inspections. In July 2020, VA provided information indicating that they will regularly monitor the SVH contractor's performance in conducting inspections through observational assessments.
- **VA does not share information on the quality of SVHs on its website.** GAO found that, while VA provides information on the quality of other nursing home care settings on its website, it does not do so for SVHs. According to VA officials, there is no requirement to provide information on SVH quality on its website, as SVHs are owned and operated by the states. VA is the only federal agency that conducts regular oversight inspection on the quality of care of all SVHs and, as a result, is the only agency that could share such quality information on its website.

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Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on state veterans homes (SVH) and the Department of Veterans Affairs' (VA) oversight of these homes.<sup>1</sup> Veterans—like over a million other Americans—rely on nursing home care to help meet their health needs. For eligible veterans whose health needs are extensive enough to require skilled nursing and personal care, VA provides or pays for nursing home care in three nursing home settings: VA-owned and -operated community living centers, public- or privately owned community nursing homes, and state-owned and -operated SVHs.<sup>2</sup> In fiscal year 2019, VA provided or paid for nursing home care for over 39,000 veterans. The majority (approximately 20,000, or 51 percent) of these veterans received care at 148 SVHs—the nursing home setting that is the focus of today's hearing.

Ensuring the quality of care provided at nursing homes—including SVHs—has become even more critical with the emergence of Coronavirus Disease 2019 (COVID-19). COVID-19 is a new and highly contagious respiratory disease causing severe illness and death, particularly among the elderly.<sup>3</sup> Because of this, the health and safety of the nation's nursing home residents—who are often in frail health and living in close proximity to one another—has been a particular concern. One of the first major outbreaks reported in the United States occurred in a Washington State nursing home in February 2020. Since then, there

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<sup>1</sup>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).

<sup>2</sup>A veteran's eligibility for fully or partially covered nursing home care is determined by the veteran's priority for care, which is generally based on the veteran's service-connected disability status. Using percentages, VA classifies veterans with service-connected disabilities according to the extent of their disability—for example, the most severely disabled veteran would be rated as having a service-connected disability of 100 percent. To the extent appropriations are available, VA must cover the full cost of nursing home care for veterans who need this care for a service-connected disability and for veterans with service-connected disabilities rated at 70 percent or more. 38 U.S.C. § 1710A(a). This requirement expires on September 30, 2020. Additionally, VA may cover this care for other veterans subject to certain considerations, such as available resources and capacity. See generally 38 U.S.C. § 1710.

<sup>3</sup>A. Patel and D.B. Jernigan, "Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak—United States, December 31, 2019–February 4, 2020," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, vol. 69: 140–146 (2020).

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has been a rapid increase in the number of COVID-19 cases in U.S. nursing homes, with more than 37,000 nursing home resident deaths reported as of July 2020—likely an undercount.<sup>4</sup>

We and others have reported on issues with COVID-19 in nursing homes. For example, in our May 2020 report analyzing the Centers for Medicare & Medicaid Services' (CMS) data on pre-pandemic infection control deficiencies in community nursing homes, we found that infection prevention and control deficiencies were the most common deficiencies cited in community nursing homes, with 82 percent of inspected nursing homes having at least one citation in the period 2013 through 2017.<sup>5</sup> Further, there have been numerous reports of outbreaks at SVHs, including a recent investigative report on the Soldiers' Home in Holyoke ordered by the governor of Massachusetts.<sup>6</sup>

My testimony today highlights key findings and recommendations from our July 2019 report, which examined for all three VA nursing home settings the use and expenditures for nursing home care and how VA uses inspections to assess and publicly share information on the quality of nursing home care.<sup>7</sup> Specifically, this testimony addresses

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<sup>4</sup>Centers for Medicare & Medicaid Services, *COVID-19 Nursing Home Data (Submitted Data as of Week Ending 07/05/2020)*, accessed July 17, 2020, <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/>. According to the Centers for Medicare & Medicaid Services, these are preliminary data that may be subject to fluctuations as nursing homes continue to submit and correct their data.

Other news reports estimate deaths among nursing home staff and residents to be above 50,000. See, for example, J. Kamp and A.W. Matthews, "As U.S. Nursing-Home Deaths Reach 50,000, States Ease Lockdowns; Facilities Weigh Coronavirus Risk of Allowing Visitors Against Ills Caused by Prolonged Isolation," *Wall Street Journal (Online)*, June 16, 2020, and Matthew Conlen et al., "More than 40% of U.S. Coronavirus Deaths are Linked to Nursing Homes," *The New York Times*, updated July 7, 2020.

<sup>5</sup>GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, [GAO 20-576R](#) (Washington, D.C.: May 20, 2020).

<sup>6</sup>Mark W. Pearlstein, *The COVID-19 Outbreak at the Soldiers' Home in Holyoke: An Independent Investigation Conducted for the Governor of Massachusetts*, June 23, 2020.

<sup>7</sup>[GAO-19-428](#).

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1. VA's expenditures for and utilization of SVHs,
  2. inspections used by VA to assess the quality of SVH nursing home care and VA's oversight of the inspection process, and
  3. information VA provides publicly through its website on the quality of SVH nursing home care.

In addition, I will highlight key actions that we recommended VA take, including VA's responses and the current status of those recommendations.

To perform the work for our July 2019 report, we analyzed VA data on expenditures for and utilization of VA-funded nursing home care and updated these data for this statement.<sup>8</sup> We reviewed policies and guidance on inspections and interviewed VA officials, including officials from VA's Geriatrics and Extended Care office, which oversees the nursing home programs. We also selected six VA medical centers based on factors such as their location and their participation with community living centers, community nursing homes, and SVHs. For each, we interviewed medical center officials and officials from corresponding VA regional offices, community living centers, community nursing homes, and SVHs. Further details on our scope and methodology are included in our July 2019 report. For this statement, we also reviewed VA's fiscal year 2021 congressional budget justification to obtain fiscal year 2019 data on SVH utilization and expenditures.

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.

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## Background

VA provides or pays for nursing home care through three separate programs, one for each of the nursing home settings in which VA provides or pays for care. In general, the three settings provide similar nursing home care—veterans receive skilled nursing care, recreational

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<sup>8</sup>For our July 2019 report, we analyzed VA data for fiscal years 2012 through 2017 reported in VA's congressional budget justifications and used in its Enrollee Health Care Projection Model.

activities, and other services. Federal oversight of care provided to veterans within the three settings is conducted by VA only or a combination of VA and CMS. See table 1 for key characteristics of the three nursing home settings.

**Table 1: Characteristics of Department of Veterans Affairs (VA) Nursing Home Care Settings, Fiscal Year 2018**

Setting	Owner	Number of participating facilities	Federal agency oversight responsibility
Community Living Centers	VA	134	VA oversees all community living centers.
State Veterans Homes (SVH)	States	148	VA conducts annual inspections for all SVHs in order to assess compliance with VA standards. The Centers for Medicare & Medicaid Services (CMS) provides oversight for about two-thirds of SVHs that receive Medicare or Medicaid payments.
Community Nursing Homes	Public or private companies	1,769	VA requires community nursing homes under contract to be certified by CMS or receive special approval from VA, and VA conducts monthly care assessments for each veteran. <sup>a</sup> CMS provides oversight for all community nursing homes that receive Medicare or Medicaid payments.

Source: GAO analysis of VA documentation. | GAO-20-697T

<sup>a</sup>According to VA policy, veterans placed in community nursing homes are generally visited monthly by a registered nurse or a social worker, but these visits may be done by phone for veterans under certain circumstances, such as for veterans in long-term placements without a significant change in health status. In those circumstances, a VA registered nurse or social worker must visit the veteran every 6 months.

The key mechanism VA uses to assess quality in each of the three nursing home settings is regular inspections, which are typically conducted annually. These inspections are used to determine the extent to which homes meet relevant VA quality standards. This oversight is

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modeled after the methods used by CMS to oversee nursing homes that participate in the Medicare and Medicaid programs.<sup>9</sup>

VA conducts an annual inspection for all SVHs and is prohibited from making payments to SVHs until it determines that they meet applicable quality standards, although VA does not exercise any supervision or control over the administration, personnel, maintenance, or operation of any SVH.<sup>10</sup> VA uses a contractor to conduct these inspections and reviews the results of the inspections.<sup>11</sup> The inspections first occur when an SVH initially seeks to become eligible for VA payments, and, once the SVH is eligible, unannounced inspections occur on an annual basis to verify that an SVH is eligible to continue to receive VA payments. For these annual inspections, the contractor generally cites deficiencies when SVHs are not in compliance with applicable quality standards. For example, deficiencies cited on inspections related to infection prevention and control can include situations where nursing home staff did not regularly use proper hand hygiene or failed to implement preventive measures during an infectious disease outbreak, such as isolating sick residents and using masks and other personal protective equipment to control the spread of infection. SVHs develop and implement corrective action plans for each deficiency identified, and the director of the VA medical center associated with the SVH approves the plan and makes sure it is implemented.<sup>12</sup>

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<sup>9</sup>CMS defines the quality standards that approximately 15,500 nursing homes nationwide must meet in order to participate in the Medicare and Medicaid programs. See 42 C.F.R. Part 483, Subpart B (2019). To monitor compliance with these standards, CMS contracts with state survey agencies to conduct inspections of each nursing home not less than once every 15 months. During the inspections, the state survey agency might identify deficiencies—instances where the nursing home does not meet an applicable standard. To address identified deficiencies, CMS generally requires nursing homes to implement corrective action plans.

<sup>10</sup>VA may inspect any SVH at such times as the Secretary of Veterans Affairs deems necessary to ensure that such facility meets the standards it prescribed. VA's policy requires that SVHs be inspected at least annually. VA requirements for SVHs cover similar categories as CMS requirements. See 38 C.F.R. Part 51, Subpart D (2019).

<sup>11</sup>VA's SVH inspection contract outlines the contractor's deliverables, such as conducting inspections within certain timeframes, and broadly states that VA will conduct annual assessments of the contractor's performance.

<sup>12</sup>A VA medical center is a facility that provides two or more categories of care—inpatient, outpatient, residential rehabilitation, or institutional extended care—to veterans.

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## VA Pays Over \$1 Billion Each Year to State Veterans Homes to Provide Care to Veterans

In addition to overseeing the quality of SVHs through inspections, VA has reported that it can provide support to SVHs as part of its “Fourth Mission” and has done so during the COVID-19 pandemic.<sup>13</sup> In response to requests for support and in coordination with the Federal Emergency Management Agency and the Department of Health Human Services, VA has deployed personnel to SVHs to provide direct clinical care, education, and training. VA has also provided SVHs with testing, equipment, and supplies.

Our analysis of VA data shows that VA pays over \$1 billion a year to SVHs to provide care to approximately 20,000 veterans. Specifically, we reported in July 2019 that, in fiscal year 2017, VA paid SVHs \$1.25 billion for an average daily census of 20,582 veterans (53 percent of the total veterans receiving nursing home care through VA).<sup>14</sup> In fiscal year 2019, VA paid SVHs \$1.17 billion for an average daily census of 20,072 veterans (51 percent of the total veterans receiving nursing home care through VA).<sup>15</sup> VA’s payments to SVHs are projected to continue to increase; VA projects it will pay \$1.7 billion to SVHs to provide care to veterans in fiscal year 2022. For information on VA’s actual and estimated

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<sup>13</sup>According to VA, VA’s Fourth Mission is to improve the nation’s preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as support to national, state, and local emergency management; and to public health, safety, and homeland security efforts. VA has included help provided to SVHs during the COVID-19 pandemic as part of its Fourth Mission activity.

<sup>14</sup>[GAO 19-428](#). For 80 percent of the veterans receiving care at SVHs, VA pays the SVH a partial daily rate. This rate covers only about a quarter of a veteran’s care costs. For example, in fiscal year 2017, VA’s average SVH per diem was \$106 for veterans without eligible service-connected disabilities. According to VA officials, the remaining daily costs are paid to the SVH by the states or the veteran and could include Medicare or Medicaid payments for SVHs that participate in those programs. VA pays SVHs the full cost of care for the remaining 20 percent of veterans in SVHs with service-connected disabilities.

<sup>15</sup>In fiscal year 2019, VA paid \$3.81 billion for an average daily census of 8,817 veterans to receiving nursing home care in community living centers. VA paid \$1.25 billion for an average daily census of 10,430 veterans to receive nursing home care in community nursing homes in the same year.

We used VA’s fiscal year 2021 congressional budget justification to provide fiscal year 2019 actual numbers for utilization and expenditures. According to VA officials, the fiscal year 2019 numbers are lower than fiscal year 2017 because VA transitioned to an “obligation at payment” model in fiscal year 2019 and only paid for 11 months of care. Under this model, obligations are not created until the point of invoice and payment, rather than at the time of referral for veterans who receive medical care at non-VA facilities. VA officials confirmed that there was not a drop in care in SVHs in fiscal year 2019; instead, the lower numbers reflect a change in when the expenditures were recorded.



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utilization and expenditures at all three VA nursing home settings, see appendix 1.

In addition to paying SVHs to provide care to veterans, VA has also provided financial support for the construction of SVHs.<sup>16</sup> In fiscal year 2019, VA was appropriated \$150 million to provide grants to states to construct new state veterans homes or to remodel existing ones. VA awarded 34 such grants to states in fiscal year 2019.

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## VA Has Opportunities to Improve Its Oversight of Inspections of State Veterans Homes

We found in our July 2019 report that VA's SVH contractor performed the required annual inspections for all SVHs for the contract year completed in 2018.<sup>17</sup> However, we also found that VA's oversight of the SVHs could be improved by requiring the contractor to cite all deficiencies on inspections and by monitoring the contractor's performance through regular observational assessments of its inspections. VA agreed with the recommendations we made to address these issues.

In reviewing VA's oversight of SVHs for our July 2019 report, we found that VA's SVH contractor had performed the required annual inspections that determine the extent to which each SVH met applicable quality standards. The contractor cited deficiencies when the quality standards were not met. For the August 2017 to July 2018 time period, VA's contractor identified 192 deficiencies in its inspections of all 148 SVHs, with an average of 1.2 deficiencies identified per inspection (see text box for an example of a deficiency at a SVH).<sup>18</sup> Deficiencies were identified at 76 SVHs (51 percent of SVHs). See appendix II for the deficiency types cited by VA's SVH contractor.

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<sup>16</sup>VA is generally authorized to pay up to 65 percent of the costs of construction of SVHs; however, construction grants for these homes depend on VA's prioritization process and state and VA funds available in any given year.

<sup>17</sup>VHA Directive 1145.01. The contract year for the SVH inspection contractor was August 1, 2017, to July 31, 2018.

<sup>18</sup>In comparison, the contractor who inspects the CLCs identified an average of 4.14 deficiencies per inspection during its contract year running from April 2017 to April 2018.

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**Example of an Infection Control Deficiency Cited at a State Veterans Home (SVH)**

Ensuring that inspections accurately assess SVH compliance with VA's quality standards has real health and safety implications for residents. For example, during one inspection conducted in April 2017, the contractor found that the facility did not have needed documentation about urinary tract infections, including whether or not the infections were facility- or community-acquired. This was problematic because a cluster of residents had urinary tract infections that had not been investigated. The contractor cited the home for failure to maintain a system that ensured accurate and daily documentation, tracking, trending, investigation, and monitoring of infections throughout the facility.

Source: GAO summary of VA infection control information. | GAO-20-697T

To address these deficiencies, VA required SVHs to produce corrective action plans and tracked the SVHs' progress addressing these issues until the deficiencies were resolved. In addition, VA officials said they took steps to address deficiencies common among SVHs. For example, to reduce SVH deficiencies related to physical environment standards for fire safety and improve SVH performance in this area, VA officials told us they held SVH town halls with a fire safety engineer and created reference guides for SVH administrators about regulatory changes in fire safety codes.

**Not all deficiencies are cited on inspections.** We found in our July 2019 report that VA does not require its SVH contractor to identify as deficiencies all failures to meet VA's quality standards. As a result, VA does not have complete information on deficiencies identified at SVHs and cannot track this information to identify trends in quality across these homes. Specifically, we identified two circumstances in which deficiencies identified at SVHs during inspections were not cited:

- VA directed its SVH contractor to cite low-level deficiencies—deficiencies considered by the contractor to pose no actual harm but with potential for minimal harm—as “recommendations” rather than deficiencies. VA officials said they do not track or monitor the nature of the recommendations or whether the recommendations have been implemented—unlike deficiencies, which they track until resolution.
- According to the SVH contractor's 2016-2017 annual summary report, SVHs can fix issues while the SVH contractor is onsite conducting an inspection to avoid being cited for a deficiency on the inspection report. Officials we interviewed at four of the six SVHs in our review specifically reported being able to make on-site corrections to avoid being cited for deficiencies. Further, our review of the contractor's annual summary report for inspections conducted between August

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2017 and July 2018 showed that the SVH contractor cited zero deficiencies at 49 percent of the SVHs inspected. VA officials cited VA’s “collegial approach” and willingness to make onsite corrections as factors contributing to this low level of deficiency citations.

According to VA officials, the non-citation practice reflects both policy and a negotiated position with the SVHs. They stated that VA is less involved in SVH oversight (than in oversight of VA-owned and -operated community living centers) because SVHs are owned and operated by the states. This approach is in contrast to the approach taken by CMS, which requires its inspectors to cite all deficiencies, regardless of severity level. We recommended in our July 2019 report that all failures to meet quality standards be cited as deficiencies on SVH inspections (see textbox). VA concurred with our recommendation and, as of July 2020, has taken some initial steps to address the recommendation, such as modifying the SVH contractor’s contract to stop the practice of using ‘recommendations’ for low-level deficiencies and beginning the process of revising a VA policy to address this practice. VA officials were not able to provide a specific date for the release of the revised VA policy.

**COVID-19 Highlights the Importance of Citing All Identified Deficiencies**

The need to adhere to rigorous infection control and prevention practices to reduce the spread of COVID-19 raises concerns over VA’s practice of not requiring all deficiencies to be cited during inspections. In our work, we have found that, compared with the Centers for Medicare & Medicaid Services (CMS), VA cites fewer deficiencies when inspecting state veterans homes (SVH). Specifically, in our July 2019 report, we found that CMS identified more deficiencies than VA in a review of a sample of inspection reports from five SVHs. While VA and CMS inspect SVHs on slightly different standards, we found that VA identified a total of seven deficiencies and made four recommendations, and CMS identified a total of 33 deficiencies for these same homes over approximately the same time period. Further, in our July 2019 report, we found that VA’s contractor cited just four infection control deficiencies in SVHs between August 2017 and July 2018. To the extent that VA does not identify deficiencies in SVH inspections and instead classifies them as “recommendations” (or that they are corrected on-site), VA lacks complete information on the extent of deficiencies at SVHs that would allow the department to more effectively monitor trends in quality issues across SVHs—such as trends related to infection control and prevention. VA has, as of July 2020, taken initial steps to require all deficiencies to be cited as such during inspections, including starting the process to revise VA policy.

Source: GAO summary of VA and CMS infection control information. | GAO-20-697T

**Not all monitoring of contractor performance is occurring.** In our July 2019 report, we found that, while VA monitored that its contractor conducted required SVH inspections and tracked the results, VA had not monitored the SVH contractor’s performance of inspections through

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regular observational assessments to ensure that contractor staff effectively determine the extent to which SVHs are meeting required standards. Specifically, VA officials told us they intended to observe the SVH contractor's inspections on a quarterly basis, which would be consistent with VA's approach to community living centers and its goal of modeling its oversight on CMS's oversight. However, at the time of our review, VA officials could not recall when VA last observed the SVH contractor's inspections. By not performing observational assessments of SVH inspections, VA does not know whether, or to what extent, VA's SVH contractor needs to improve its ability to identify SVHs' compliance with quality standards. This increases the possibility that quality concerns in some SVHs could go overlooked, potentially placing veterans at risk.

While VA officials did not provide specific reasons why they had not performed the observational assessments, they noted that VA's oversight of SVHs is less involved than its oversight of CLCs because VA does not exercise any supervision or control over the administration, personnel, maintenance, or operation of any state home.

In our July 2019 report, we recommended that VA develop a strategy to regularly monitor contractor performance in conducting SVH inspections, ensure performance results are documented, and ensure that any needed corrective actions are taken. VA agreed with this recommendation and provided information to address it in July 2020. Specifically, VA provided information indicating that they will regularly monitor through observational assessments the SVH contractor's performance in conducting inspections, document these assessments, and address corrective actions.<sup>19</sup>

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## VA Does Not Share Information on Quality of State Veterans Homes on Its Website

We found in our July 2019 report that, while VA publicly provides information on care quality for community living centers and community nursing homes through its *Access to Care* website, VA does not provide

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<sup>19</sup>In July 2020, when VA provided information to address this recommendation, inspections of SVHs had been put on hold because of COVID-19. As such, it was not possible for VA to provide us with an example of an observational assessment completed since making the changes in response to our recommendation.

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information on the quality of SVHs.<sup>20</sup> VA's website is an important tool for veterans and their families to help inform their decision making when choosing a nursing home. VA collects VA-prescribed inspection, quality measure, and staffing data as part of its survey process that could be used to develop and distribute quality information for each SVH.<sup>21</sup> However, according to VA officials, there is no requirement to provide information on SVH quality on its *Access to Care* website, as SVHs are owned and operated by the states.<sup>22</sup>

VA is the only federal agency that conducts regular oversight inspections on the quality of care in all SVHs and, as a result, is the only agency that could share quality of care information on all SVHs on its website. Specifically, while CMS and VA both conduct oversight of about two-thirds of SVHs, the other one-third of SVHs are only overseen at the federal level by VA.<sup>23</sup> States may or may not conduct their own oversight. For example, the Soldiers' Home in Holyoke in Massachusetts is not a state-licensed facility, nor is it enrolled as a provider with CMS. As a result, it is not inspected by the relevant state agency or by CMS as are other Massachusetts nursing homes. It is only inspected annually by the VA and every three years by a private accrediting organization; therefore, these are the only potential sources of quality information about this SVH.

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<sup>20</sup>The *Access to Care* website can be used independently by all veterans and their families—regardless of their eligibility for VA-funded care—to evaluate their nursing home care options. See Department of Veterans Affairs, Nursing Home Care for Veterans website, accessed July 15, 2020, <https://www.accesstocare.va.gov/CNH/Statemap>.

<sup>21</sup>For example, SVHs are required to make a comprehensive assessment of a resident's needs, which could be used to generate quality measures. See 38 C.F.R. § 51.110(b) (2019). However, VA officials told us that they cannot provide comparable information for some measures that rely on claims or payroll data, because they do not have this information for SVHs.

Some of this information is available to the public at the local level, but it is not currently provided by VA. For example, SVHs are required to make the results of the most recent VA inspection of the home available for examination in a place accessible to residents.

<sup>22</sup>VA did not identify any limitation in its authority to publish quality information for SVHs on its website, nor were we able to identify any such limitations.

<sup>23</sup>CMS provides oversight for the SVHs that receive Medicare or Medicaid payments. Some SVHs that do not receive Medicare or Medicaid payments may still be inspected by a state agency. The specific state agency that oversees the SVH may vary by state. However, some SVHs may not be inspected by CMS or by the state, and, instead, VA is the only inspecting agency.

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If VA's *Access to Care* website included SVH information, it would be the only readily accessible source of quality care information publicly available to veterans and their families for certain SVHs.<sup>24</sup> As a result, we recommended that VA provide information on the quality of all SVHs that is comparable to the information provided on the other nursing home settings on its *Access to Care* website. VA concurred in principle and, as of July 2020, had begun taking some steps to address this recommendation, such as exploring options for presenting SVH quality measure data. However, VA does not expect to complete their actions until July 2022.

In conclusion, the findings of our July 2019 report regarding VA's oversight of SVH quality and the sharing of quality of care information become even more critical in the context of the COVID-19 pandemic, given that the elderly or disabled veterans living in SVHs are particularly vulnerable to the spread of infection. It is imperative that VA ensure the health and safety of these veterans, whose health care needs are extensive enough to require the skilled nursing and personal care provided in nursing homes such as SVHs. While VA has provided support to SVHs through its Fourth Mission to aid in their response to COVID-19, by implementing our recommendations VA can better ensure that veterans receive high quality care (including care related to infectious diseases) and that it shares publicly the quality of care information it alone collects on all SVHs.

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

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## GAO Contact and Staff Acknowledgements

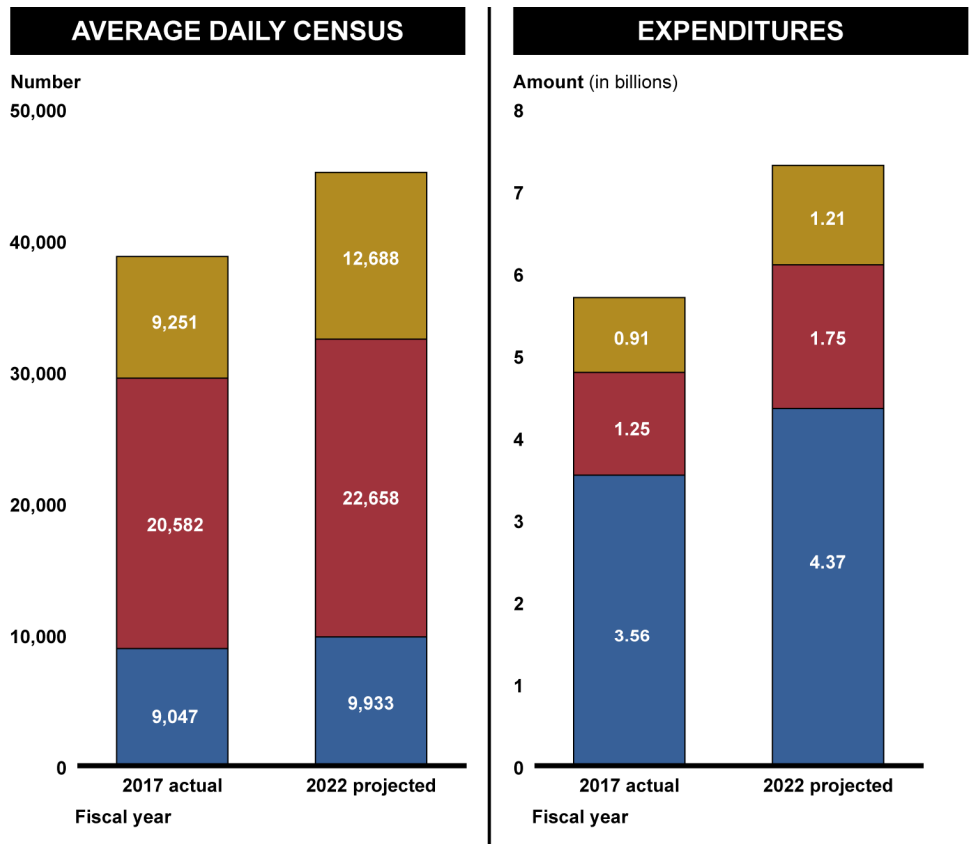
If you or your staff have any questions about this testimony, please contact Sharon M. Silas, Director, Health Care, at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition to the contacts named above, key contributors to this statement were Karin Wallestad (Assistant Director), Summar C. Corley (Analyst-in-Charge), and Laurie Pachter. Also contributing to the underlying report for this statement were Kye Briesath, Krister Friday, Jim Melton, Vikki Porter, Mandy Pusey, and Jennifer Whitworth.

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<sup>24</sup>CMS's *Nursing Home Compare* website contains quality care information for the approximately two-thirds of SVHs that are also inspected by CMS.

# Appendix I: Department of Veterans Affairs Actual and Projected Utilization of and Expenditures for Nursing Homes

**Figure 1: Department of Veterans Affairs Actual and Projected Utilization of and Expenditures for Nursing Homes, by Setting, Fiscal Years 2017 and 2022**



Community Nursing Homes      State Veterans Homes      Community Living Centers

Source: GAO analysis of VA information. | GAO-20-697T

# Appendix II: Deficiencies Identified from Inspections of All 148 State Veterans Homes, 2017 to 2018

**Table 2: Deficiencies Identified from Inspections of All 148 State Veterans Homes, August 2017 to July 2018**

Deficiency type and description	Number of deficiencies (percent)
<p><b>Physical environment.</b> The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>For example, an emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.</p>	93 (48)
<p><b>Quality of care.</b> Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>For example, based on the comprehensive assessment of a resident, the facility management must ensure that: (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p>	36 (19)
<p><b>Resident assessment.</b> The facility management must conduct initially, annually, and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.</p> <p>For example, facility management must ensure the results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care.</p>	33 (17)
<p><b>Resident Behavior and Facility Practices.</b> Restraint—The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention.</p> <p>Abuse—The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect; corporal punishment; and involuntary seclusion.</p> <p>Staff treatment of residents—The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	10 (5)
<p><b>Dietary services.</b> The facility management must provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident.</p> <p>For example, the facility management must employ a qualified dietitian either full time, part time, or on a consultant basis.</p>	6 (3)
<p><b>Infection control.</b> The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>For example, to prevent the spread of infection, the facility must: (1) isolate a resident when the infection control program determines that isolation is necessary to prevent the spread of infection; (2) prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact would transmit the disease; and (3) require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p>	4 (2)
<p><b>Quality of life.</b> The facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>For example, the facility management must promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality; the resident has a right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans for care; and the resident has a right to organize and participate in resident groups in the facility.</p>	4 (2)



**Appendix II: Deficiencies Identified from  
Inspections of All 148 State Veterans Homes,  
2017 to 2018**

Deficiency type and description	Number of deficiencies (percent)
<p><b>Resident rights.</b> The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident.</p> <p>For example, the facility must have written policies and procedures regarding advanced directives (e.g., living wills). These requirements include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advanced directive.</p>	3 (2)
<p><b>Pharmacy services.</b> The facility management must provide routine and emergency drugs to its residents (or have an agreement in place for an outside agency to provide them) and must have a system for disseminating drug information to medical and nursing staff.</p> <p>For example, the facility must have a licensed pharmacist review the drug regimen of each resident at least once a month and the pharmacist must report any irregularities to the primary physician and the director of nursing for action.</p>	2 (1)
<p><b>Physician services.</b> A physician must personally approve in writing a recommendation that an individual be admitted to a facility and each resident must remain under the care of a physician.</p> <p>For example, the facility must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency.</p>	1 (1)
<b>Total</b>	<b>192</b>

Source: GAO analysis of VA documentation. | GAO 20-697T

Notes: The contract year for the state veterans home inspection contractor was from August 1, 2017, to July 31, 2018. During this period, the contractor conducted six repeat inspections.

The total number of deficiencies may include deficiencies from one state veterans home that VA does not consider a skilled nursing facility.

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