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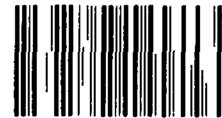
VA HEALTH CARE

Issues and Concerns for VA Nursing Home Programs



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Human Resources Division

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August 8, 1986

The Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate

The Honorable G. V. Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives

Responding to an expected surge in demand for nursing home services, the Veterans Administration (VA) proposed in its fiscal year 1987 budget to increase resources for VA-supported state and community nursing home programs, which it claimed are less costly than the VA-owned nursing home program. According to this initiative, VA would revise its national goals for distribution of nursing home beds among its three programs so that the mix would be: 30 percent VA-owned, 40 percent community, and 30 percent state. This would replace the current goal of 40, 40, and 20 percent respectively.

Drawing on our past and ongoing work regarding VA's nursing home programs, we have identified several issues that we believe bear directly on VA's ability to deliver nursing home care in fiscal year 1987 and beyond. In preparing this briefing report, our objective was to identify issues your committees may want to address in reviewing VA's provision of nursing home care. We interviewed VA, state, and private sector officials and visited the nursing home care unit at the VA medical center in Lebanon, Pennsylvania, the state veterans' nursing home in Hollidaysburg, Pennsylvania, and five community nursing homes that contract with the Lebanon VA medical center. With the assistance of the Iowa Foundation for Medical Care, we reviewed placement histories, demographic characteristics and level of care needs of a sample of patients in these homes. The foundation also assessed the capability of these facilities to deliver the care needed by the patients in residence.

The following matters bear directly on VA's ability to deliver nursing home care in fiscal year 1987 and beyond:

- Is VA's use of national goals realistic in view of differing local needs and resources?
- Will VA have access to needed beds in state veterans' nursing homes and contract nursing homes?
- Is comparable information on the medical and nursing needs of patients in the three nursing home programs obtainable, and would it be useful to VA for short-term and long-range planning?
- Considering all cost elements among the three VA programs, would shifting away from the nursing home care unit program result in the savings VA anticipates?
- Are VA's per diem payments to contract community nursing homes higher than necessary?
- How does a veteran's disability status affect nursing home placement and length of stay, and do VA's practices in this regard circumvent intended policy?
- Will VA be able to identify and correct potential and actual problems in the delivery of contract nursing home care?
- What are the benefits and drawbacks of each of the VA nursing home programs for veterans, community nursing home operators, and VA itself?

Officials from VA reviewed a draft of this briefing report and gave us their comments, which we incorporated where appropriate. We are sending copies of this report to the Director, Office of Management and Budget; the Administrator of Veterans Affairs; and the Chairmen and Ranking Minority Members of the congressional committees concerned with VA long-term care issues. We also will make copies available to others on request. For additional information, please contact me on 275-6207.

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ABBREVIATIONS

CBO	Congressional Budget Office
GAO	General Accounting Office
ICF	intermediate care facility
MEDIPP	medical district initiated program planning
OIG	Office of the Inspector General
SNF	skilled nursing facility
VA	Veterans Administration

VA HEALTH CARE: ISSUES AND CONCERNS FOR VA NURSING HOME PROGRAMS

BACKGROUND

The Veterans Administration (VA) sponsors nursing home care through three programs: (1) its own nursing home care unit program, (2) a contract community nursing home program, and (3) a state veterans' nursing home program. All three programs treat veterans with disabilities that may be either service-connected or nonservice-connected and all can provide either skilled or intermediate nursing home care. The programs differ in a number of respects, including cost to VA, limitations on length of stay, and the relative desirability of placement in them for veterans and their families.

The programs can be characterized as follows:

--VA nursing home care unit program. In fiscal year 1985, the 115 VA-owned and operated units served 20,442 patients and had an average daily census of 9,556 patients. These facilities provided a wide range of services including nursing care, rehabilitative therapies, social activities, supportive personal care, and individual adjustment services. VA obligated about $390 million for the operation of its nursing homes.

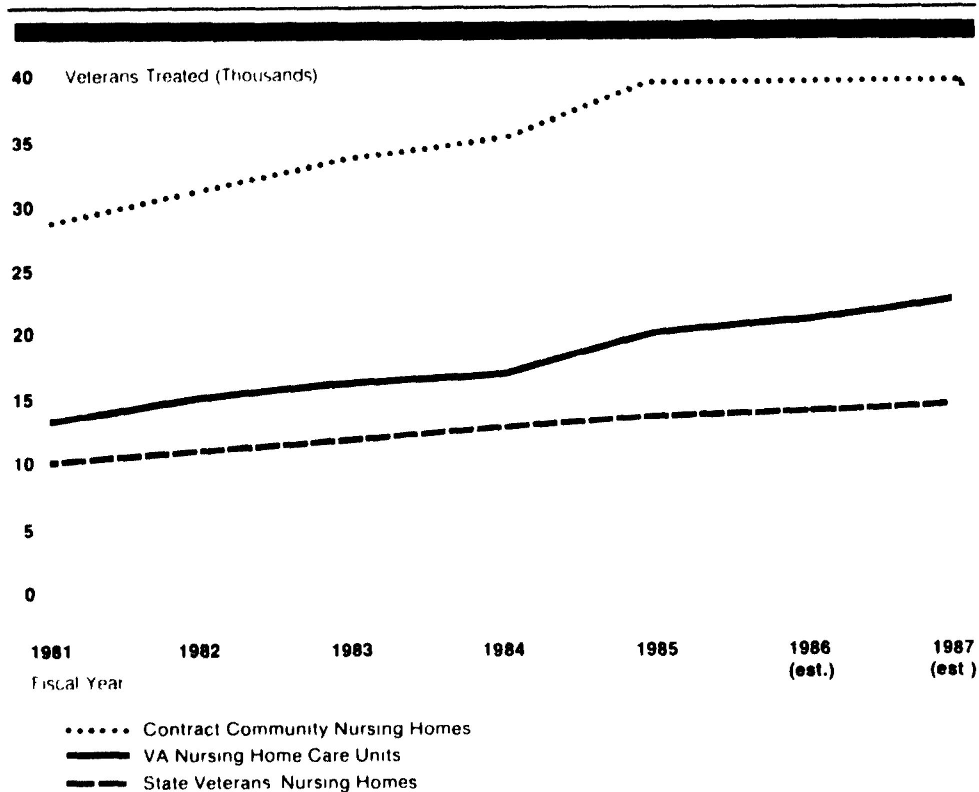
--Contract community nursing home program. Similar services were provided by approximately 3,300 facilities under contract to VA, treating 38,907 VA-supported patients in fiscal year 1985. The average daily census was 11,444. VA obligated about $269 million for this program.

--State veterans' nursing home program. Forty-three facilities in 28 states provided skilled or intermediate nursing services for 13,540 veterans and had an average daily census of 7,846. VA supports the state programs through grants, subsidizing up to 65 percent of the costs of construction or renovation of nursing home facilities, and through a legislatively determined amount per patient-day. In fiscal year 1985, VA obligated about $50 million for the per diem payments.

The number of patients the VA programs serve has been steadily increasing. For example, the anticipated average daily census of 31,827 across the three programs for fiscal year 1987 represents a 42-percent increase since fiscal year 1981. The number of veterans receiving nursing home care in each of the three programs has steadily increased in the last 5 years (see fig. 1) and is expected to grow at a faster pace through the

year 2000. In fiscal year 1987, VA estimates, the VA nursing home care units will treat 28.9 percent of VA-supported patients receiving nursing home care, the state program, 19.4 percent, and the community program, 51.7 percent.

Figure 1: Veterans Treated by Each VA Nursing Home Program (1981-1987)



VA predicts that demand for nursing home care will accelerate rapidly because the pool of veterans 65 and over, 3 million in 1980, will increase to 7.2 million by 1990, and that by 2000 this age group will peak at about 9 million veterans, accounting for nearly two out of three males over age 65 in the nation. Furthermore, four million of these veterans will be 75 years of age or older. Because multiple, chronic conditions become prevalent in the over-75 age group, their risk of institutionalization is great.

Two recent studies have examined VA's future needs. One, Veterans Administration Health Care: Planning for Future Years, was published by the Congressional Budget Office (CBO) in April 1984; the second, Caring for the Older Veteran, was issued by VA in July 1984. The two studies differ considerably in the assumptions they make and their estimates of VA's needs.

CBO projected a sizable increase in the need for nursing home beds. If current VA policies continued, CBO estimated that VA would need about 35,000 beds in 1990 (about a 40-percent increase from 1982) and about 52,000 in the year 2000 (about a 105-percent increase from 1982.) VA, on the other hand, estimated a need for an even larger increase in the number of long-term beds, from 50 to 106 percent by 1990 and from 128 to 189 percent by 2000. VA's figures, however, include both nursing home and domiciliary beds. The substantial differences between the VA and CBO estimates stem largely from VA's belief that veterans will request its services at a much higher rate in the future than is now the case.

It is difficult to estimate accurately the number of veterans who will seek nursing home services from VA. In addition to demographic changes, other factors are expected to influence the number of veterans who request these services. Demand for VA services may rise, for example, because the cost of nursing home care in the private sector is increasing, and bed availability outside the VA system may not expand at a rate to match the growing demand. On the other hand, such increased demand may be curbed by changes in VA eligibility requirements (e.g., imposition of a means test for veterans with nonservice-connected disabilities) and the expansion of noninstitutional programs such as adult day care and hospital-based home care. In general, however, demand is expected to increase in the future.

It is in this context that VA has proposed to revise its goal for the percentage of beds allocated to each of the three programs. The proposed mix of 30 percent VA-owned, 40 percent community, and 30 percent state is to replace the current goal of 40, 40, and 20 percent respectively.

OBJECTIVE, SCOPE, AND METHODOLOGY

In this briefing report, our objective is to discuss several issues arising from VA's proposed change in focus for delivering nursing home care. These issues bear directly on VA's ability to deliver such care in fiscal year 1987 and beyond. We considered information from prior GAO reports and from VA reports--including several from the VA Office of the Inspector General (OIG). Further sources were studies from health planners, government study groups, and others on the delivery of nursing home care by VA and the non-VA public and private sectors. We also reviewed VA program guides and interviewed VA central office staff responsible for administering the three nursing home programs and representatives from a national nursing home trade association.

As part of this project, we developed a case study of the delivery of VA-supported nursing home care in Pennsylvania. We met with officials of the Pennsylvania state veterans' home system and interviewed administration, nursing, and social work staff at seven facilities: the VA medical center in Lebanon, Pennsylvania; the state veterans' nursing home in Hollidaysburg, Pennsylvania; and five community nursing homes in south-central Pennsylvania that contract with the Lebanon VA medical center. Also, we talked with officials in the Pennsylvania Departments of Public Welfare, Health, and Aging and representatives from proprietary and not-for-profit nursing home trade associations in Pennsylvania.

Between September 1985 and February 1986, we reviewed patient placement histories and demographic characteristics at the seven facilities we visited. We contracted with the Iowa Foundation for Medical Care to assess the level-of-care needs of patients at these facilities and the capabilities of the facilities to deliver the required care.

The Iowa Foundation is a nationally known physician-based health care organization that conducts reviews in acute and long-term care settings. As Iowa's peer review organization, the foundation reviews Medicare patients under a contract with the federal Health Care Financing Administration. It also reviews Medicaid-sponsored patients for the Iowa Department of Human Services and more than 80 percent of all private pay hospital admissions, including those covered by Iowa's two Blue Cross plans. Involved in long-term care reviews for 7 years, the foundation over that time has conducted more than 160,000 medical record reviews in Iowa's 446 long-term care facilities to determine medical necessity for placement and quality of care provided. For our case study, the foundation's assessment team consisted of two practicing registered nurses and a practicing physician.

In this report, we discuss seven issues related to VA's provision of nursing home care: nursing home planning, increased use of contract and state beds, comparative data on patient needs, comparative costs of the programs, per diem payments to contract homes, length of placements, and quality of care.

For each issue, we highlight key points, present background material, and identify specific concerns for the committees' consideration. In the final sections, we discuss factors for consideration by (1) veterans and the VA regarding patient placement in each of the three programs and (2) for community nursing home operators in accepting VA patients.

ISSUE 1: NURSING HOME PLANNING

- VA incorporated into its medical district initiated program planning (MEDIPP) process our previous recommendation that it construct nursing home care units only after considering local needs and resources and less costly alternatives.
- VA's goal of a 30-40-30 provider mix (30 percent VA-owned, 40 percent community, 30 percent state) for its nursing home beds does not recognize the local characteristics and resources of the medical districts or the areas served by each medical center.
- VA's proposed shift in emphasis away from VA-owned nursing home facilities should be supported by its MEDIPP data to the extent that those data accurately project the demand for nursing home beds and the availability of such beds.

In 1982, we reported that the planning criteria and processes VA used to justify proposed nursing home construction projects did not adequately consider local conditions or less costly alternatives to new construction.[1] Specifically, we found that VA

1. justified new projects using national demographic and needs projections with little input about the characteristics and resources of the primary service areas of the medical districts or medical centers;

2. did not adequately consider the option of providing more care in community nursing homes by expanding its use of existing legislative authority to contract for care; and

3. did not adequately consider converting, renovating, or changing the mission of its existing facilities to help meet the need for more nursing home beds.

VA had planned to meet veterans' nursing home care needs through its three programs in approximately the following ratio:

--40 percent in VA nursing home care units,

--40 percent in contract community nursing homes,

--20 percent in state veterans' nursing homes.

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[1]VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes (GAO/HRD-82-114, Sept. 30, 1982).

VA based this ratio on historical patterns of the programs, we were told. We were especially critical of VA's use of a set ratio and showed that VA's national goal of 40-40-20 could result in unequal access to care for veterans in different medical districts. Therefore, we also question VA's proposed new ratio (30-40-30) for fiscal year 1987. VA should continue, we believe, to determine the need for VA nursing home care units based on local needs and resources.

We recommended that, beginning with its fiscal year 1985 budget request, VA include information on local needs and resources and discuss its consideration of less costly alternatives as part of the budget justification for each proposed nursing home construction project.[2] VA's subsequent budget justifications have contained more data to justify the projects. But we recently pointed out that two of six VA proposals for nursing home construction projects that we reviewed were not supported by MEDIPP data.[3]

The process VA planners follow to justify construction of a VA nursing home in a particular district allows them to consider whether community and/or state nursing homes would be able to meet the projected demand:

1. Planners first determine the rate at which veterans have been using nursing home services and apply that rate to the veteran population projected for their district in some target year (for example, 1995).

2. Assuming that between 12 and 16 percent (a proportion VA has historically used) of veterans needing nursing home care would seek it through VA, planners calculate the number of veterans VA should expect to support in nursing homes in the target year.

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[2]VA Is Making Efforts To Improve Its Nursing Home Construction Planning Process (GAO/HRD-83-58, May 20, 1983).

[3]VA Justification for Two Nursing Home Care Construction Projects in Its Fiscal Year 1985 Budget Request (GAO/HRD-84-66, May 15, 1984); VA Justification for Construction of Nursing Home Care Facilities at Durham, North Carolina, and Prescott, Arizona (GAO/HRD-84-84, July 31, 1984); VA's Methodology for Setting Priorities for Nursing Home Care Construction Projects for Fiscal Year 1986 (GAO/HRD-85-70, May 17, 1985); and VA Justification for Construction of Nursing Home Care Units at Amarillo, Texas, and Tucson, Arizona (GAO/HRD-85-80, Aug. 12, 1985).

3. Estimating the number of nursing home beds in community facilities and state veterans' homes that would be available to meet that demand, the planners then assume that any demand not thus met would have to be accommodated through VA-owned facilities.

We reviewed the construction justifications for several nursing home care units proposed in VA's fiscal year 1985 and 1986 budgets. In all cases, VA had sufficient MEDIPP data available to estimate whether community and state homes, together with existing VA facilities, could meet the projected demand for care. But in some cases, VA had not used all available data from local sources, and we questioned the need for the proposed construction.

Specific Concerns

1. Why has VA reverted to a national goal for the distribution of beds among the three nursing home programs?

2. To what extent will VA's national goals, rather than the current or projected availability of nursing home beds in the area served by each VA medical district, influence a decision to expand the number of VA nursing home care unit beds?

3. What conclusions can be reached from existing MEDIPP data about the expected availability of community and state nursing home resources in the areas served by each VA medical district? Do these conclusions support VA's changed focus for the three nursing home programs?

ISSUE 2: INCREASED VA USE OF CONTRACT AND STATE NURSING BEDS: AVAILABILITY, ACCESS, AND IMPACT

- VA's proposed expansion of placements in the community and state nursing home programs assumes that beds will be available and VA will have access to them.
- VA has a limited ability to expand state veterans' nursing home programs without additional federal and state commitments.
- In almost every state, community nursing homes have occupancy rates above 90 percent; throughout the United States, differences in occupancy rates exist.
- VA could expand its share of community nursing home beds without the construction costs involved in expanding its own nursing home program or the state veterans' nursing home program.
- Even if VA were to double the number of its community nursing home placements, it would use less than 2 percent of the current bed supply.

Demographic trends indicate a rapid growth in the number of people aged 75 and over, the group most in need of nursing home care. Furthermore, the proportion of U.S. nursing home residents aged 85 and over is projected to increase from 31 percent in 1980 to 43 percent in 2000. Because this population is more susceptible to chronic, multiple conditions than are younger people, the shift implies a growing proportion of patients with heavy nursing care needs. According to VA, the aging of World War II and Korean Conflict veterans is expected to produce a proportionately greater increase in the demand for its nursing home care through 2010 than for the U.S. population as a whole. If VA is to meet the increased demand by expanding the use of contract and state beds, such beds must be available to VA for placement of its patients.

Community Nursing Home Beds

The Institute of Medicine reported in 1986[4] that nursing home occupancy averaged over 90 percent in almost every state. The Alpha Center, a nonprofit health policy and planning center,

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[4] Improving the Quality of Care in Nursing Homes, Institute of Medicine, National Academy of Sciences, Washington, D.C.: 1986.

reported in February 1986[5] that occupancy rates differed in various parts of the country. For example, in Arizona, the occupancy rate was 83 percent, while in Minnesota there was no comparable surplus of nursing home beds and some facilities had waiting lists. Consequently, VA's plans to expand use of its community nursing home program should consider the possibility of regional bed shortages. VA has no direct control over its construction of community nursing home facilities, but we found evidence that some community nursing home operators might increase the number of beds in their facilities if VA were to use them.

Using current rates of occupancy and bed supply to predict future rates would require an assumption that all other influencing factors would have no effect. The nursing home industry, however, is in a state of transition. Many divergent factors affect both current and future occupancy rates and bed supply, e.g.:

--Alternatives to institutional long-term care, such as home health or residential day care, may increase the availability of nursing home beds.

--Hospitals are beginning to convert excess acute care beds to long-term nursing home beds.

--Strict controls some states have placed on the construction of nursing home facilities to curtail soaring Medicaid costs may limit the supply of community nursing home beds.

--Because Medicare's new prospective payment system may lead to earlier discharges from acute care facilities, demand may increase for skilled nursing home beds.

--Low Medicaid reimbursement rates in some states may discourage private investment in nursing home expansion.

Even if the bed supply in community nursing homes expands, VA may lack access to these beds for a number of reasons: (1) it will face increased competition from the overall elderly population for access to those beds, (2) the bed supply may not expand in geographic areas in which VA will need them, and (3) community nursing home operators may not want VA contracts (see p. 38).

Although VA will have to contend with factors that limit accessibility, some circumstances may serve to increase it. In

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[5]Deregulation Is Growing Trend for State CON Programs, Alpha Center, Washington, D.C.: Feb. 1986.

fiscal year 1985, the average daily census in VA's community nursing home program nationally was 11,444. In contrast, there are approximately 1.5 million community nursing home beds in the country that are Medicare/Medicaid-certified. By increasing outreach efforts to homes not part of its program, VA may be able to expand its placements in community nursing homes.

Also, VA may be able to gain access to even more beds by expanding its placements in homes currently under contract. In our case study at the Lebanon VA medical center, we found only a small number of VA-sponsored patients in each contract nursing home. In the five contract homes we visited, the number of VA-supported patients ranged from 4 to 20. Further, because our sampling plan was designed to emphasize contract homes with higher veteran caseloads, these numbers were relatively high, considering all homes under contract to the Lebanon medical center. This pattern was not, however, limited to Lebanon. Of the 267 community nursing homes under contract to eight other VA medical centers, 84 had no male contract patients in residence. Of the remaining 183 homes, 134 had caseloads of four or fewer VA-supported male patients.[6]

State Veterans' Nursing Home Beds

Through its construction grants, VA is more directly involved in expanding the number of beds in the state veterans' nursing home program, but it can not expand this program on its own. States must take the initiative by requesting federal approval and providing their share of funds for the projects.

Several factors may hinder expansion of beds in the state program: the cost to both federal and state governments to construct and expand such facilities, and the fact that not all states have these programs (some have not applied for them). As of March 1986, 29 states offered nursing home care to veterans under state programs; four additional states had projects approved for funding. Finally, it can take years to develop and approve projects. In fact, VA estimated in February 1985 that there was a 6-year backlog of eligible but unfunded state home projects. As of March 1986, the state program had a backlog of projects involving 3,426 nursing home beds in 17 states.

Expanding the state program may not necessarily meet VA's needs. First, expansion may not occur in the geographic areas of VA demand. Second, each state has its own set of eligibility criteria and admission policies that often differ from VA priorities. For example, VA's highest eligibility priority is for

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[6]We collected these data on male patients as part of another project. Males constitute over 95 percent of the overall veteran population.

veterans requiring treatment for service-connected disabilities. Most state nursing home programs do not differentiate admission priorities by this factor. In addition, the separate states' eligibility criteria for admission (e.g., veterans' income level, age, and length of state residency) also vary.

Impact on Medicaid-Supported Beds

By far the largest government payer for nursing home care, Medicaid provides partial or full support to approximately two-thirds of the country's nursing home residents. Because of the typically higher per diem rate paid for VA-supported patients, community nursing home operators in many states may prefer VA patients over Medicaid patients. (We describe on page 26 the per diem rates for VA- and Medicaid-supported patients.) An increase in VA's use of community nursing homes, therefore, might result in more difficult access for Medicaid-supported patients, the majority of whom are women. The total impact of increased VA use of community nursing homes could be small, however, because even with doubling of VA use, VA would still account for less than 2 percent of the total current bed supply.

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Incentives and disincentives for community nursing home operators to accept VA patients are discussed on page 38.

Specific Concerns

1. How will VA respond to variations in community nursing home operators' desire and ability to absorb increased numbers of VA-supported patients?

2. To what extent do disincentives for community nursing home operators to contract with VA limit VA's ability to place patients? What can VA do to make its patients more desirable to facility operators without raising per diem rates?

3. To what extent would increased outreach efforts by VA medical centers expand the available pool of community nursing home beds in their service areas? How many of the approximately 1.5 million Medicare- or Medicaid-certified beds could be used by the VA?

4. What incentives is VA considering to encourage states to expand their veterans' nursing home programs? Are projected long-range funding levels for the state program sufficient to reduce the length of time between project approval and project funding?

5. Will VA's MEDIPP data be used to assign approval and funding priorities for individual construction projects under the state veterans' nursing home program?

6. What impact will Medicare's prospective payment system for acute care have on the availability of community nursing home beds for VA use?

ISSUE 3: USEFULNESS OF COMPARATIVE DATA ON MEDICAL AND NURSING NEEDS OF VA-SUPPORTED NURSING HOME PATIENTS IN ALL PROGRAMS

- VA does not collect comparable data on conditions and medical needs of patients in its three nursing home programs.
- But, based on our Pennsylvania case study, we believe that comparable data can be obtained on the levels of care required by patients in the three programs.
- In our case study, the VA nursing home care unit, the five community nursing homes, and the state veterans' nursing home all provided a range of nursing services, rehabilitative therapies, social activities, and supportive personal care. The mix of services provided, however, varied by facility, and not every facility offered the same services.
- Collection by VA of national information on nursing home patients' conditions and needs could provide valuable data for planning the specific types of facilities and services required to meet the needs of an increased number of elderly veterans.

VA lacks a management information system that collects comparable data on medical and nursing needs of all VA-supported nursing home patients. Two VA-sponsored data collection efforts, the long-term care survey and the annual patient census, are limited to patients in VA nursing home care units only. VA has other patient-specific data, but they also are of limited value in comparing patients across programs. These additional data are not comparable, as they are contained in the separate systems used in each of the three VA nursing home programs to classify patients' level-of-care needs. Furthermore, states vary widely in the definitions they use to determine patients' levels of care. For example, definitions may differ as to the amount of resources needed for each patient or the severity of a patient's illness.

VA makes no distinction in its program guidance regarding differences in medical or nursing needs of patients treated in any of the three nursing home programs nor does it specify in detail all services the programs are to offer. The missions of the programs are quite similar; all are intended to provide needed skilled or intermediate nursing care and related medical services.

The VA nursing home care unit aims to provide (1) nursing and other care to patients needing long-term rehabilitation to restore them to their optimum level of functioning and (2) care that will prevent or delay deterioration of patients having profound physical disabilities and/or behavior management deficiencies. The mission of the contract community nursing homes is much the same, but this program is designed to help the veteran and his/her family make the transition from hospital to community. The goal of state veterans' nursing homes is to provide needed nursing and medical care, but the specific mission of each state veterans' home is defined by that state. Based on the similarity of missions across the three programs, the services offered should be comparable.

Assessment of Patients' Conditions and Needs

To determine whether comparable data were available and the extent to which they could be useful to planners, we contracted with the Iowa Foundation for Medical Care, a physician-based statewide peer review organization. We asked the foundation to assess both patients' level-of-care needs and the capability of facilities within each program to deliver the care needed by the patients in residence. As part of the patient assessment, the Iowa Foundation reviewed records from a random sample of patients selected in stages. At the first stage, we chose seven facilities: the VA nursing home care unit in Lebanon, Pennsylvania, the state veterans' nursing home in Hollidaysburg, Pennsylvania, and five community nursing homes contracting with the Lebanon VA medical center. The latter were chosen from the eligible universe of 19 such facilities by a sampling plan designed to emphasize contract homes with higher veteran caseloads. At the second stage, we selected a random stratified sample of records of 164 VA-supported male patients in the seven facilities for review. For comparison, the foundation reviewed a stratified, random sample consisting of 61 records of Medicaid-supported male patients in the five contract facilities. To ensure that we reviewed a full range of patient needs, the samples were stratified within each facility by the level of nursing care (skilled or intermediate) in which each facility had classified the patients on the day of our visit. The foundation collected data in September and October 1985.

Although the Iowa Foundation's findings cannot be generalized beyond our case study, our sampling approach allows generalization to the VA nursing home care unit at Lebanon, the state veterans' nursing home at Hollidaysburg, and all the community nursing homes under contract to the Lebanon VA medical center.

In its review of patient records, the Iowa Foundation assessed patients at two points in time: upon admission to the most recent level-of-care classification and at the time of its

on-site visit. For each patient's record, the foundation reviewed 17 dimensions to make its assessment of severity of illness and intensity of services needed: mental status; ability to move extremities; ability to ambulate; skin condition; respiratory condition; bowel and bladder status; activities of daily living (ability to dress, groom, and perform hygiene activities); self-feeding ability; ability to see, hear, and communicate; medications required; psychological and social components affecting functional status; maladaptive behavior; alcohol/chemical dependence; rehabilitation potential; stability of condition; discharge plan; and diagnoses. When needed for individual patients, the foundation reviewers obtained information from facility staff who knew the patient's condition. If additional information was required, the reviewers observed the patient.

Using these assessments, the Iowa Foundation determined the level of care required for each patient. To ensure comparability, the same standards for placing patients in these categories were employed for all seven facilities in the three programs and for the Medicaid-supported patients as well.

The foundation used six level-of-care categories for the patient assessment: skilled/rehabilitation, skilled/heavy care, intermediate/heavy care, intermediate, residential care, and home care. Because the foundation's assessments of the records resulted in some categories having very few cases, we combined them to permit analysis. The percentages of patients in each of four level-of-care categories, by VA program area, for the seven Pennsylvania facilities are shown in table 1.

Table 1:

Classification of Patients by Level of Care and Program Area in Seven Pennsylvania Facilities

Level-of-care category	Percentage of patients in each program area[a] VA nursing home care unit	State nursing home	VA contract community nursing homes	Medicaid-supported in contract facilities
Skilled[b]	2.0	0.5	7.4	0.8
Intermediate/ heavy care	36.7	34.1	23.0	36.8
Intermediate	54.2	63.1	67.1	58.8
Residential/ home care[c]	7.1	2.2	2.5	3.7

[a]Data were weighted to account for the fact that, within each of the four settings, skilled nursing facility (SNF) and intermediate care facility (ICF) patients were not included in the sample in proportion to their actual numbers at each facility. Percents may not add to 100 due to rounding.

[b]Combines patients classified as skilled/rehabilitation and skilled/heavy care.

[c]Combines patients classified as needing residential care or home care.

We found no statistically significant difference in the median level of care needed across the four groups of patients. For each group, the median was in the intermediate care category.

Groups can have the same median, but still have different proportions of patients in each of the four levels of care. Because of small sample sizes, we were unable to test whether the four groups were the same or different in the overall proportion of patients that fell into the various level-of-care categories. But a test between the two groups that appeared most different, VA nursing home care unit patients and VA-supported contract community nursing home patients, showed no statistically significant difference in their overall distributions among the level-of-care categories.

Also, there were no statistically significant differences in the median level of care needed by all VA-supported patients considered as a group on the one hand and the Medicaid-supported patients in the community nursing homes on the other. Nor did

the overall proportions of patients classified as needing various levels of care differ significantly between these two groups.

Our findings are limited to this case study and cannot be generalized further because the Lebanon VA nursing home care unit may not be representative of all such VA facilities. The Lebanon unit does not provide some intensive services, such as tube feedings and administration of oxygen that nursing homes can provide. The Lebanon VA medical center does provide such services, however, in its large (305-bed) intermediate medicine care unit. This may mean that the patients in Lebanon's nursing home care unit are less severely ill than would be the case of patients in other medical centers with no or few intermediate medicine beds.

Assessment of Services Offered

The foundation toured each of the seven facilities, observed patients, and reviewed a sample of patients' medical and nursing records. At each facility, the foundation reviewed staffing levels, services provided, job requirements, staff qualifications, policies and procedures manuals, and incident-reporting systems.

All of the facilities provided a range of nursing services, rehabilitative therapies, social activities, and supportive personal care services, but not all offered the same services. This was particularly apparent in the provision of tube feedings and respiratory care. The state veterans' nursing home provided tube feedings, administration of oxygen, and tracheostomy care as needed for patients in our sample. Although the VA nursing home care unit did not offer these services, contract homes provided tube feedings and administered oxygen to some of the sampled patients. (Patients in contract homes whose records we reviewed did not require tracheostomy care, but the homes had the capability to provide it.)

* * * * *

On the basis of our data collection efforts in Pennsylvania, we believe that comparable information can be obtained on patients across the three VA nursing home programs. Standardized data collection instruments and procedures could be used to obtain such patient-specific information as severity of illness, types and frequency of services needed, levels of care required, and appropriateness of placement.

Comparable information on all patients receiving VA-supported nursing home care would be useful for both short- and long-range planning. Such information would assist in identifying the needs of the population currently being served and the

types of programs or facilities required in the future. Suppose, for example, the data show that in a given geographic area more VA-supported patients with psychiatric disorders are in the VA nursing home care unit than in community nursing homes or the state veterans' nursing home. Then VA program officials could evaluate whether the programs are meeting the expected mission, and VA planners can project whether the area will have enough resources to meet future nursing home demand. Also, if comparable information were acquired on male nonveterans in community nursing homes, VA should be able to determine the degree to which veterans require special facilities, programs, and services that nonveterans do not.

Specific Concerns

1. To what extent do VA-supported patients have comparable conditions and needs across the three nursing home programs? To what extent are the conditions and needs of VA-supported male patients different from those of male nonveteran nursing home patients?

2. Should VA routinely collect comparable data to assess patients' conditions and needs across the three programs?

3. Should there be differences in the objectives, targeted populations, or services offered in the three nursing home programs?

4. Is there a need for each nursing home facility within a program to provide the same services?

5. To what extent do services offered across and within each of the three programs vary by geographic location? Are geographic variations in services a function of differences in patients' needs? Are certain patients' needs unmet in some parts of the country because specific services are unavailable?

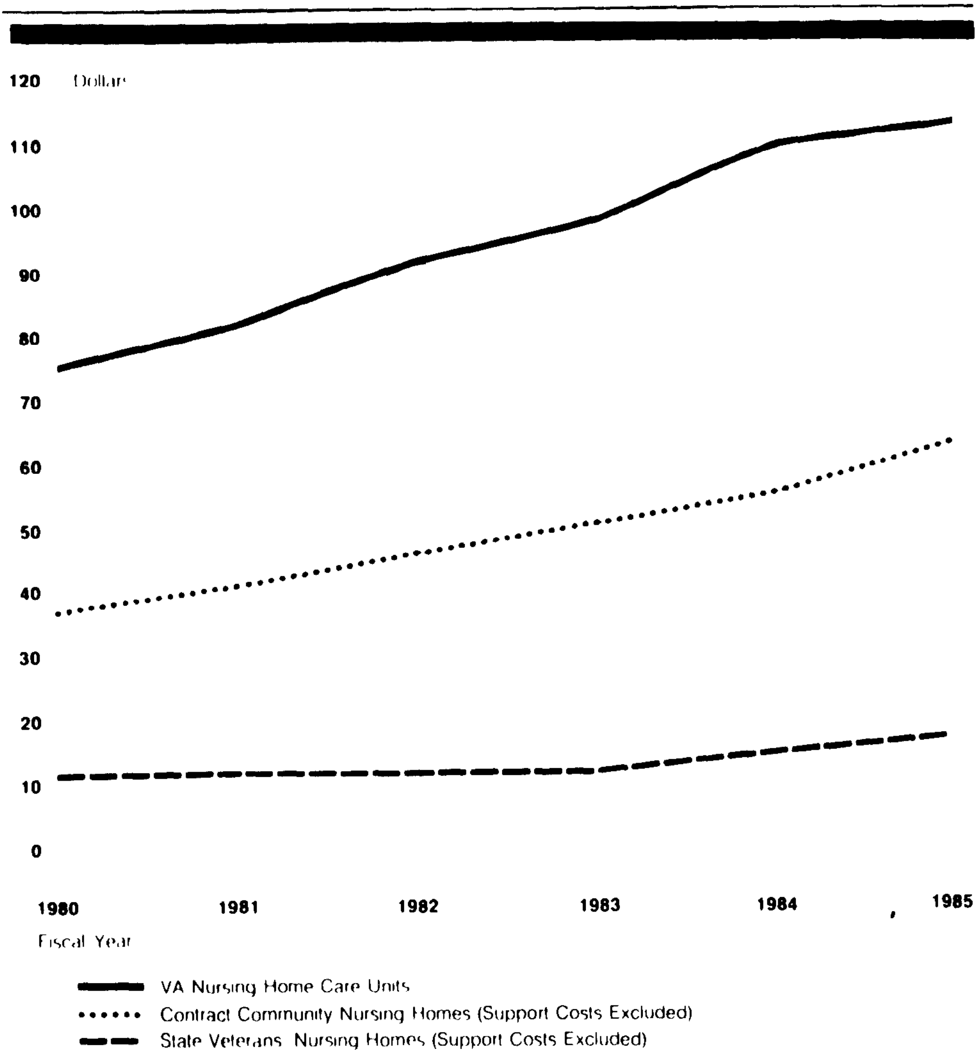
6. For purposes of patient placement or referral, to what extent does each VA medical center use an inventory of nursing home services offered by nursing homes in its service area? How does the VA assure that the services offered in a contract community nursing home or a state veterans' nursing home meet the needs of the veterans placed there?

ISSUE 4: COMPARATIVE COSTS OF VA'S NURSING HOME PROGRAMS

- VA's average obligations per patient day varied among the three nursing home programs for the period we reviewed.
- The obligations VA reported for the three programs are not directly comparable because certain costs are included in some rates and excluded in others.

We examined VA records showing average obligations per patient day during the period 1980-85 for the three nursing home programs, as shown in figure 2. The amounts varied among the programs, but cannot be considered comparable because of the way they are calculated, as discussed below.

Figure 2: VA Average Obligations per Patient Day (1980-1985)



Source Veterans Administration

For nursing home care units, VA's medical care cost allocation system is intended to capture the full amount of direct and indirect costs in its per diem rates. These costs include depreciation on the physical plant, administrative costs, and costs of medical and nursing services provided by VA medical centers for patients residing in the nursing home care units.

The average per diem rate reported by VA for contract community nursing home care primarily reflects direct charges to the VA by the contract homes. But these rates may not reflect the full cost of care for patients in this program. For a community nursing home contracting with the Lebanon VA medical center, for example, the per diem rate may exclude support costs for such items as (1) equipment, e.g., wheelchairs or special beds provided by the VA, (2) transportation to non-VA facilities and VA inpatient and outpatient facilities for routine or special diagnostic testing or care, e.g., dental and eye services, (3) such testing or care, and (4) expensive services that may not be included in facility contracts, e.g., oxygen and physical therapy.

The per diem rate for state veterans' nursing homes is set by law (38 U.S.C. 641). Two additional costs to VA are not reflected in this per diem rate: (1) VA subsidies--up to 65 percent of the construction and renovation costs of these facilities--and (2) VA monthly pensions and aid and attendance benefits to veterans in these facilities, which continue without reduction. (Pension benefits are paid to low-income veterans who had wartime service and are permanently and totally disabled; veterans aged 65 and older and not working are considered permanently and totally disabled. Aid and attendance benefits are payments for the care of the veteran provided by another person.) These benefits are reduced for veterans without spouses and/or dependents when nursing home care is provided under the other two programs.

Specific Concerns

1. VA's proposed shift in emphasis away from VA-owned nursing homes because of potential savings in the cost of medical and nursing care requires comparison of the full cost of such care in each of the three programs. Considering all cost elements involved in providing medical and nursing care, what are the actual comparable per diem costs in each nursing home program?

2. Considerations of the relative costs of providing nursing home care for VA-supported patients generally exclude differences in the amount of VA pension and aid-and-attendance benefits paid to many patients in each program. What would be the effect on the total costs to VA of each program if these benefits were included in the calculations?

ISSUE 5: PER DIEM PAYMENTS TO CONTRACT COMMUNITY NURSING HOMES

- VA medical centers are expected to use prevailing Medicaid nursing home reimbursement rates as an index to community rates when negotiating a contract.
- Although there may be differences in the basic coverage, VA contract rates are typically higher than Medicaid reimbursement rates.
- VA per diem rates may be higher than Medicaid rates because of

  --lack of outreach to obtain competitive rates from prospective contract facilities,

  --lack of patient care cost information from community nursing homes prior to contract negotiation,

  --payment of higher wage and benefit rates to comply with the Service Contract Act of 1965, as amended, and,

  --lack of obligation on the part of contract nursing homes to admit heavy-care, high-cost VA patients.
- VA's per diem payments may be higher than appropriate because of VA's failure to revise patients' level-of-care designations in a timely fashion.

Each VA medical center negotiates contracts with approved community nursing homes in its area. The contracts specify the amount VA will pay for each day of care the home provides to a VA-supported patient. When negotiating these contracts, medical centers are expected to use the Medicaid rate for nursing home care as an index to prevailing community rates. Medical centers can negotiate a rate up to the predetermined VA maximum, generally $77 per day in fiscal year 1986. Furthermore, the intermediate nursing home care rate must be at least 10 percent less than the average rate paid by the contracting VA medical center for skilled care.

Typically, VA's per diem rate has been higher than the rates established for the Medicaid program. In fiscal year 1983 (the most recent year with comparable data between the programs), VA reported that its combined skilled and intermediate contract home per diem payment averaged $50.81, while Medicaid's average rates for skilled and intermediate care were $40.69 and $30.33 respectively. Data from our case study in September 1985

showed that for the patients in our sample the average VA daily payment for skilled care was $69.18. This was $24.23 or 54 percent higher than the average Medicaid skilled care payment for patients in our sample. For patients receiving intermediate nursing home care, the average VA daily payment was $62.55. This was $25.87 or 71 percent higher than the comparable Medicaid intermediate care payment for patients in our sample.

Per diem rates may be higher than Medicaid rates because:

- Lack of outreach to obtain competitive rates from prospective contract facilities produces rates that, according to the VA Inspector General,[7] are too high.

- When negotiating contract rates with individual community nursing homes, VA medical centers do not always use available cost data that each community nursing home provides to state Medicaid programs. Consequently, some VA medical centers do not know the actual cost of care when negotiating rates.

- If VA rates were equivalent to Medicaid rates, some community nursing homes would not accept VA patients.

- The Service Contract Act of 1965, as amended, requires that wage and fringe benefit rates for service employees on federal contracts totaling more than $2,500 be based on rates that the Secretary of Labor determines as prevailing for service workers in the locality. For our case study, we discussed this with VA officials at Lebanon, administrators of community nursing homes contracting with the Lebanon VA medical center, and representatives of a national nursing home trade association. A community nursing home's compliance with this act may increase its costs, we learned. This may lead to either higher negotiated per diem rates or classification of VA-supported patients at higher levels of care than are medically required, thereby requiring VA to pay a higher per diem rate. It occurs when facilities will only care for VA-supported patients in skilled nursing wards or beds that are generally staffed with full-time permanent employees who receive full fringe benefits as a way to satisfy the requirements of the Service Contract Act. We found varying requirements for federal support of nursing home services under Department of

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[7] Audit of the VA Community Nursing Home Program, VA/OIG, Rept. 3R2-A07-064, Mar. 30, 1983; Audit of Newton D. Baker VA Medical Center, Martinsburg, West Virginia, VA/OIG, Rept. 5R2-FO3-126, Sept. 30, 1985; and Audit of VA Medical Center, Oklahoma City, Oklahoma, VA/OIG, Rept. 6R6-F03-006, Oct. 24, 1985.

Labor regulations, which specifically exempt Medicare and Medicaid contracts (e.g., for nursing home services) from requirements of the act. Yet services provided under similar contracts to VA-supported patients in the same facilities trigger the provisions of the act. This difference may serve to increase both VA's difficulty in securing placements and the rates negotiated for the placements it does find. In a previous report,[8] GAO suggested that the Congress consider repealing the Service Contract Act.

- Contract nursing homes are not required to admit VA-supported (or Medicaid-supported) patients. VA negotiates a facility-wide rate rather than an individual patient rate. Therefore, the VA per diem rate may have to be higher than needed for some patients to facilitate placement of the heavy-care, high-cost patients in contract facilities. As such, it also creates an incentive for community nursing homes to admit low-care, low-cost patients.

VA payments to community nursing homes may be higher than appropriate because level-of-care designations may not be reviewed in a timely fashion. Of the seven facilities visited for our case study, all but one (a community nursing home) had misclassified VA-supported patients in our sample. When the level-of-care need of a VA patient in a contract home changed, VA had no standard follow-up mechanism in place to ensure that the rate paid was appropriate for the care needed and/or provided. Generally, in such cases, we found patients classified at higher levels of care than required.

Specific Concerns

1. Would VA per diem rates be lower if there were greater competition among community nursing homes for VA contracts?

2. To what extent can VA contracting officers negotiate lower per diem rates by using cost information reported by that facility to state Medicaid offices?

3. To what extent can VA establish mechanisms to help ensure that, when a patient's needs change, regardless of the nursing home program in which the patient is placed, the level of care received changes and, where appropriate, payments change accordingly?

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[8]The Congress Should Consider Repeal of the Service Contract Act (GAO/HRD-83-4, Jan. 31, 1983).

4. To what extent are contract nursing homes inhibited from contracting with VA because of the need to conform with the provisions of the Service Contract Act?

5. To what extent do the ways community nursing homes comply with the wage and benefit requirements of the Service Contract Act lead to higher and more costly levels of care than are medically required for VA-sponsored patients?

6. Is VA's access to contract nursing beds limited by private operators' having minimum and maximum percentages of beds filled by VA-supported patients because of the costs involved in conforming to provisions of the Service Contract Act?

7. What incentives could VA provide for contract facilities to take the more costly heavy-care patients?

ISSUE 6: LENGTH OF NURSING HOME PLACEMENT

- VA is authorized to support veterans without service-connected disabilities in its nursing homes or state homes indefinitely; but in community homes, VA support for these veterans is generally limited to 6 months.
- According to our analysis of VA nationwide data and projections from 1980 to 1988, veterans without service-connected disabilities are more likely to be in residence in VA nursing home care units for indefinite lengths of stay than in community nursing homes on 6-month contracts.
- Use of multiple extensions for veterans with nonservice-connected disabilities in contract nursing home may not be appropriate.

Veterans being treated for service-connected disabilities have no statutory limitations on their length of stay in any of the three VA nursing home programs. VA support for veterans being treated for nonservice-connected disabilities in VA nursing home care units and state veterans' homes continue as long as the veteran is in residence, but VA sponsorship for these patients in contract nursing homes is generally limited to 6 months (38 U.S.C. 620). Under certain conditions, described below, VA can extend these contracts.

Disability Status and
Nursing Home Placement

We found evidence that, on a national basis, veterans with nonservice-connected disabilities are more likely to be in residence in VA nursing home care units for indefinite lengths of stay than in contract community nursing homes for up to 6 months (see fig. 3). Several recent VA Inspector General reports[9] criticized this practice at individual VA medical centers. In our case study, we found that only 20 percent of sampled veterans at the VA nursing home care unit had service-connected disability status. (The Iowa Foundation for Medical Care found, however, that only 13 percent of patients in the same sample were actually being treated for service-connected disabilities.)

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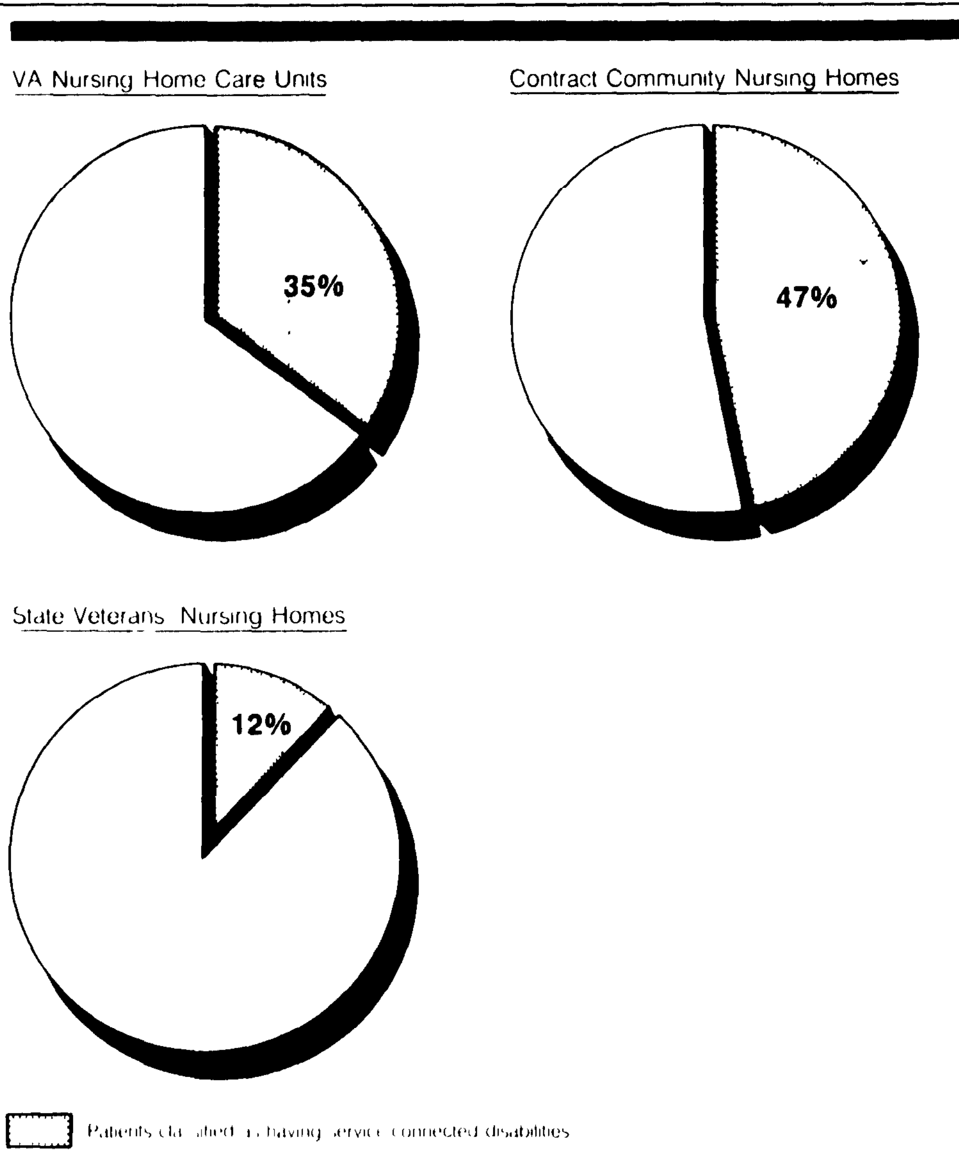
[9]VA/OIG, Audit of VA Medical Centers for: West Haven, CT, Rept. 5R1-F03-007, Oct. 26, 1984; Syracuse, NY, Rept. 5R1-F03-029, Dec. 28, 1984; Boise, ID, Rept. 5R8-F03-098, July 23, 1985; Northport, NY, Rept. 5R1-F03-117, Sept. 16, 1985; Montrose, NY, Rept. 6R1-F03-001, Oct. 10, 1985; and Brockton/West Roxbury, MA, Rept. 6R1-F03-071, Mar. 31, 1986.

Similarly, 20 percent of the sampled patients at the state veterans' nursing home and 45 percent in the contract nursing homes had service-connected disabilities. (The Iowa Foundation reported that the percentage of sampled patients in the state veterans' nursing home and contract nursing homes actually being treated for service-connected disabilities were 12 and 30, respectively.)

Figure 3: Percentage of Patients Classified as Having Service-Connected Disabilities in VA Nursing Home Programs (1982)



Note Latest available data VA projections through 1988 remain the same

Source Veterans Administration

Multiple Extensions of 6-Month Contracts

Placement in contract nursing homes generally is limited by law to 6 months except for veterans requiring nursing home care for service-connected disabilities or veterans hospitalized for service-connected disabilities but requiring nursing home care for any disability. This period was intended to allow time for the patients and their families to make the transition from hospitalization to placement in the community. According to the VA, contract extensions beyond the 6-month limitation should be held to a minimum and should meet several conditions: (1) both medical and economic needs exist, (2) circumstances of a most unusual nature prevent discharge or assumption of financial responsibility by the family or community, and (3) approval of the VA medical center director is obtained.

The VA Inspector General, however, has issued several reports criticizing the use of multiple 6-month extensions at some medical centers. According to the Inspector General[10] and Lebanon VA medical center administrators and social work service staff, several factors may result in multiple extensions. These typically include delays in beginning discharge planning and difficulties in finding financial support for continued care after eligibility for VA support expires. Inappropriate extensions are costly. Also, because VA can only support a limited number of beds, such extensions restrict the number of additional veterans who can be served.

Specific Concerns

1. What effect does a veteran's disability status have on placement in a VA nursing home care unit versus placement in a contract community nursing home?

2. What action is VA taking to reduce the use of multiple extensions of a patient's community nursing home contract and ensure that the criteria for extending patients' community nursing home contracts are appropriately applied?

3. What action is VA taking to ensure timely discharge planning for all nursing home patients in the three programs?

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[10] Audit of the VA Community Nursing Home Program, VA/OIG, Rept. 3R2-A07-064, Mar. 30, 1983; Audit of Newton D. Baker VA Medical Center, Martinsburg, West Virginia, VA/OIG, Rept. 5R2-F03-126, Sept. 30, 1985; and Audit of VA Medical Center, Brockton/West Roxbury, Massachusetts, VA/OIG, Rept. 6R1-F03-071, Mar. 21, 1986.

ISSUE 7: ASSURING QUALITY OF CARE

- VA is responsible for assuring delivery of quality care in all three nursing home programs.
- All seven facilities across the three programs in our case study provided adequate care the majority of the time, according to the Iowa Foundation.
- Expansion of the contract community nursing home and state veterans' nursing home programs may require increased efforts by VA medical centers to assure delivery of quality care.

For VA to assure delivery of high quality care in its nursing home programs, it must be able to identify actual or potential problems on both a system-wide and patient-specific level. It then must be able to follow through on necessary corrective actions. These actions may include (1) issuing and monitoring the implementation of new instructions for care of individual patients in specific facilities, (2) removal of individual patients from substandard facilities, and (3) termination of contracts with community nursing homes whose performance is substandard.

VA's responsibilities for assuring quality care differ for each of the three nursing home programs. Quality assurance mechanisms and procedures affecting VA nursing home care units are part of the larger quality assurance program at each VA medical center. The capability of each VA nursing home care unit to deliver quality care is assessed by the VA's Systematic External Review Program and by the Joint Commission on Accreditation of Hospitals, an independent assessment organization.

Although individual state veterans' nursing homes may have their own quality assurance programs, the VA also maintains a quality assurance role in these facilities. To inspect state veterans' nursing homes, the VA uses a team comprised of members from many disciplines including medicine, nursing, nutrition, social work, engineering, and medical records. These teams annually assess each facility's capability to deliver care and the care actually provided.

VA standards for contract community nursing homes require that they (1) be licensed by the state, (2) meet Medicare/Medicaid criteria for skilled or intermediate care, and (3) meet VA's additional standards for fire safety and provision of certain nursing services. If a contract nursing home has been approved by the Joint Commission on Accreditation of Hospitals, the VA medical center director has the option of accepting that

evaluation or conducting a full evaluation prior to establishing a contract and annually thereafter. In all cases, VA medical center social work and nursing services staff conduct monthly follow-up visits for each patient placed in a contract nursing home.

For our Pennsylvania case study, the Iowa Foundation for Medical Care assessed capabilities of programs and facilities to deliver the care required by patients in residence. This assessment included a review of each facility's responses to questionnaire items on staffing levels, services provided, and bed occupancy. The reviewers also examined facility policy manuals, job descriptions, and incident reports to assess the adequacy of policies and procedures, staff qualifications, and follow-through on written policies for patient care. In its assessment, the foundation included information learned from tours of each facility, observation of patients, review of patient records, and conversations with facility staff and patients. The care provided was adequate the majority of the time in all facilities visited, the foundation judged.

Because the VA plans to increase placements into contract nursing homes and state veterans' nursing homes, we asked the reviewers to assess the capability of the facilities visited in our case study to provide quality care to an increased case load of VA-supported patients. An increased rate of VA placement into state and contract nursing homes, the reviewers concluded, could produce an increase in the numbers of patients with psychiatric disorders for whom the facilities might not be able to provide quality care. Such patients appear in greater percentages in the VA nursing home population than in the nonveteran nursing home population, according to VA. (In our case study, patients with psychiatric impairments were found frequently in the VA nursing home care unit, but VA reports that this facility is above the median of VA nursing home care units in the percentage of psychiatrically impaired patients in residence.)

According to the reviewers, a shift of more VA patients into contract and state home programs would require educating staff in contract nursing homes and state veterans' nursing homes in the understanding of psychiatric disorders and interpersonal techniques used in their treatment. Such training could be provided by VA social work and nursing staff.

Specific Concerns

1. With a possible expansion of the number of homes and patients under contract, to what extent will VA quality assurance systems be effective in identifying and correcting potential and actual problems in the delivery of contract nursing home care?

2. Do the various VA medical center offices sharing responsibility for contract care (e.g., supply, administrative services, pharmacy, nursing, and social work) effectively coordinate their actions when contract care deficiencies are identified?

DECISION FACTORS FOR VETERANS IN SELECTING A VA NURSING HOME PROGRAM

In performing our case study, we learned from VA, state home, and community nursing home officials and staff that veterans and their families play major roles in deciding which of the three VA care programs is best suited for their needs. Various factors can be incentives or disincentives to pick a program. We present below the views of these officials and staff on incentives and disincentives veterans may have in deciding among the three programs.

VA Nursing Home Care Units

Incentives

- Veterans classified as having nonservice-connected disabilities are not statutorily limited in the length of time they may remain.
- Veterans are provided with special activities and events geared to their military backgrounds.
- Veterans experience a special camaraderie, as all patients have military experience.
- Veterans generally have freedom of movement about the buildings and grounds.

Disincentives

- The facility usually is located at a distance from veterans' families and friends, making visits difficult and perhaps causing the veteran to lose contact with community events.
- Veterans without spouses and/or dependents will have their monthly VA pensions and aid and attendance benefits reduced after a specified period.

VA Contract Community Nursing Homes

Incentives

- The facility usually is located close to veterans' family and friends, making visits easy to arrange and allowing patients to remain in contact with local community events.
- The facility may be smaller and less institutional than in the other two programs.

Disincentives

- Because veterans classified as having nonservice-connected disabilities generally are limited to 6 months of VA contract care they may have to pay for additional nursing care. This could place a drain on their financial resources and those of their families.
- After a specified time period, veterans without spouses and/or dependents will have their monthly VA pensions and aid and attendance benefits reduced.
- Veterans may have little in common with other patients, and social activities devoted to veterans may be few in number.
- Because there may be restrictions on patients' freedom of movement through the facility and the surrounding community, veterans may find contract homes confining.

State Veterans' Nursing Homes

Incentives

- Veterans classified as having nonservice-connected disabilities are not statutorily limited to a specified length of stay.
- Veterans continue to receive VA monthly pension and aid and attendance benefits.
- At some state veterans' nursing homes, veterans are not charged fees for their nursing care.
- Veterans are provided with social activities and events geared to their military backgrounds.
- As most patients have military experience, veterans experience a special camaraderie.

Disincentives

- Usually, the facility is located at a distance from families and friends, making visits difficult and perhaps causing the veteran to lose contact with local community events.
- Veterans in some state veterans' nursing homes may be charged for services at a rate that may make this program more costly to them or their families than the other two programs.

DECISION FACTORS FOR COMMUNITY NURSING HOME OPERATORS IN ACCEPTING VA PATIENTS

While community nursing home operators may find VA contracts desirable, they encounter difficulties in working with VA. The incentives and disincentives we identified for community nursing operators to accept VA patients are listed below.

Incentives

- Typically, VA contract rates are higher than rates for Medicaid-supported patients.
- VA has a reputation for paying its bills promptly.
- VA payments provide an additional source of income for community nursing homes.
- While VA negotiates the level of care needed for each patient, community nursing homes maintain complete autonomy in deciding whether to accept a VA-supported patient at any given rate.
- VA may provide specialized services and equipment, such as physical therapy and oxygen, at no cost to the facility.
- VA agrees to remove a contract patient from a home if the home determines that for any reason it cannot adequately care for the veteran.
- VA provides complete histories and medical evaluations for each patient.
- Most VA patients are male; this helps community nursing homes maintain a more desirable male-to-female ratio.
- VA patients receiving nursing home care for service-connected disabilities are entitled to remain in a community nursing home at VA expense as long as their conditions call for such care.

Disincentives

- VA's initial and annual inspections may duplicate existing inspections, disrupt daily routines, and unnecessarily create administrative burdens.
- At any point in time, VA may provide only a few contract patients to a community nursing home, making the administrative burden involved not commensurate with the number of prospective VA patients.

- VA contracts for veterans with nonservice-connected disabilities generally are limited to 6 months. This is not long enough, operators feel, for VA, patient, or family to plan for any care needed after contract eligibility expires. Thus, an operator may hesitate to accept contract patients with no clear financial resources other than VA support out of concern that they will remain and the operator will have to absorb some of the costs for continued care.

- VA contracts with community nursing homes must comply with the Service Contract Act of 1965, as amended. As discussed on page 27, compliance may increase the costs of salaries and fringe benefits to the nursing home.

- VA support for community nursing home patients under contract may not always cover all the nursing, medical, and administrative costs the homes incur.

DECISION FACTORS FOR VA IN PLACING VETERANS IN NURSING HOME PROGRAMS

From VA's perspective, there are certain advantages and disadvantages to placing a veteran in any one of the three nursing home programs. These factors may affect VA's ability to meet the changing goals described in its fiscal year 1987 budget justification. In identifying the advantages and disadvantages to VA in using each of the three programs, as shown below, we have assumed that patients would receive adequate care in all instances.

VA Nursing Home Care Units

Advantages

- VA wishes to keep all its existing nursing home beds occupied.
- For some veterans placed in this program rather than in a state veterans' nursing home, VA's monthly payments for pensions and aid and attendance benefits are reduced.
- VA may reduce the additional administrative costs associated with the other programs (e.g., inspections, transportation of patients, and monitoring of care received by contract patients).

Disadvantages

- VA must pay all construction costs.
- Average per diem costs reported by VA are higher than those reported for the other two programs.

Contract Community Nursing Homes

Advantages

- For some veterans placed in this program rather than in a state veterans' nursing home, VA's monthly payments for pensions and aid and attendance benefits are reduced.
- VA can readily use these nursing beds without paying high construction costs.
- Average contract per diem costs reported by VA are almost one-half of those reported for VA nursing home care units.

- Use of contract beds for veterans with service-connected disabilities (who have no time limits on their lengths of stay) creates bed availability in VA nursing home care units for veterans with nonservice-connected disabilities.

Disadvantages

- A VA medical center may find it difficult to monitor patients' conditions, services needed, and appropriateness of charges in the numerous nursing home facilities it has under contract.
- VA may have difficulties placing psychiatric patients and assuring that appropriate care is given them.
- VA has no direct control over expansion of the number of beds and facilities in any location because states' health planning and health financing policies strongly determine the expansion of the nursing home industry.
- VA may incur additional administrative costs (e.g., inspections, transportation of patients, and monitoring of care received by contract patients).

State Veterans' Nursing Homes

Advantages

- VA need not pay the full costs of construction.
- VA's per diem payment is low.
- VA will support patients on indefinite lengths of stay regardless of the patients' disability status.

Disadvantages

- VA pays up to 65 percent of construction costs.
- VA's payment of monthly pensions and aid and attendance benefits to veterans continues without reduction.
- VA has no direct control over the number of beds available and the admission of individual patients.

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