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Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Better Data Needed to Effectively Use Limited Nursing Home Resources

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GAO

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Health, Education, and
Human Services Division

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December 20, 1996

The Honorable Alan K. Simpson
Chairman
Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) reported spending about $1.6 billion in fiscal year 1995 on nursing home care for more than 79,000 veterans or about 14 percent of the estimated demand by veterans for such care.[1] VA provides nursing home care in its own facilities, contracts with community nursing homes, and pays state veterans homes a portion of the cost of care provided to eligible veterans. All veterans are eligible for nursing home care essentially on a first-come, first-served basis within VA budget constraints.

As the number of veterans aged 65 and older increases to about 9.3 million (from 8.8 million in 1995) by the year 2000, the demand for nursing home care is expected to increase. Funds available for VA nursing home care, however, are expected to be limited.

This report responds to your request for the following information about VA nursing home programs:

- the distribution of veterans in VA, community, and state veterans nursing homes;
- the costs to VA for VA, community, and state veterans nursing homes;
- the factors affecting VA's use of community and state veterans nursing homes; and
- whether VA, community, and state veterans homes provide comparable quality care.

To obtain information on the distribution of veterans in the three types of nursing homes and the factors affecting use of community and state veterans homes, we surveyed the 164 VA medical centers that had nursing home care units or contracts with community nursing homes. We received

[1]VA has developed a model, using data from the National Nursing Home Survey conducted by the Department of Health and Human Services' (HHS) National Center for Health Statistics, to estimate veterans' future demand for nursing home services. VA's model is based on (1) veteran population by age group and (2) veteran utilization rates per 1,000. Using 1995 data, VA's model estimated an average daily census of about 235,000 veterans needing nursing home care. In 1995, VA's average daily census in nursing homes was about 34,000 or 14 percent of the estimated demand.

responses from all of these centers. Their responses were based on fiscal year 1994 data, the most current available at the time. We supplemented the information from the survey with discussions with VA officials and community and state veterans nursing home administrators. Also, we reviewed cost reports to identify the relative costs to VA for each type of nursing facility, previous studies on nursing home costs and quality, and VA policies and procedures on monitoring nursing home care and cost reporting. In addition, we visited 2 VA, 10 community, and 5 state veterans nursing homes. Our review team included a registered nurse (RN) who interviewed nursing home personnel and reviewed the care provided to 95 veterans in the facilities we visited drawing on Medicare provider certification and survey procedures.[2] The patients were randomly selected to be a representative sample from the VA and state veterans nursing homes. We reviewed the total veteran population served under VA contracts at each community home. We performed our work between July 1995 and November 1996 in accordance with generally accepted government auditing standards.

Results in Brief

The number of veterans receiving VA-financed or -provided nursing home care increased from 72,889 in 1985 to 79,373 in 1995, though the costs of these services increased from about $710 million to $1.6 billion in the same period. Among veterans currently receiving VA-financed or -provided nursing home care, 40 percent receive such care in VA nursing homes; 36 percent, in state veterans nursing homes; and 24 percent, in community nursing homes. By contrast, in 1985 about 40 percent of the veterans served by VA were cared for in community nursing homes, and only 33 percent were served in VA nursing homes.

VA's reported cost for providing care in VA nursing homes is considerably higher than its cost for doing so in community and state veterans homes. VA records for fiscal year 1995, the most current available, indicate that VA's daily per patient cost was $213.17 for veterans in VA nursing homes, $118.12 for veterans in community nursing homes, and $35.37 for veterans in state veterans homes. Some of the cost differences are attributable to differing patient mix and staffing patterns among the facility types. The precise cost differences cannot be determined, however, because of weaknesses in VA's cost data.

[2]We focused on services provided and indicators of patient care problems such as the use of restraints (physical and chemical), skin integrity, ability to perform activities of daily living, level of consciousness, and the use of exercise and physical and occupational therapies to maintain or improve functioning.

Several factors influence VA decisions on where to place nursing home patients. First, some parts of the country have a shortage of community nursing home beds. Second, many veterans and their families prefer to use VA nursing homes instead of community nursing homes because VA generally pays for only 6 months of nursing home care in community nursing homes for veterans with no service-connected conditions. After 6 months, patients' assets are used until the patients become eligible for Medicaid; in addition, their pensions are reduced when Medicaid assumes responsibility for them. VA homes have no maximum service period, and only higher income, nonservice-connected veterans must contribute to the cost of their care in these facilities. Third, VA sometimes has difficulty getting community nursing home services in those locations where its reimbursement rates are lower than other purchasers of such services. VA has several reimbursement initiatives under way to enhance its access to community nursing homes. Also, VA's use of state veterans homes is limited by the number of such beds available and by some states' criteria for admitting veterans to these homes—criteria that are more restrictive than VA's. For example, some states admit only veterans who served during wartime.

We and others have found differences in the quality of care provided to veterans by the various types of nursing homes. The VA nursing homes we visited appeared to provide more comprehensive care to veterans than most of the community and state veterans nursing homes we visited. Although the care provided in the community and state homes we visited generally met quality standards, we identified quality-of-care issues at both types of homes. For example, veterans in community nursing homes were less likely to receive restorative therapies and more likely to be subjected to physical and chemical restraints than veterans in VA homes.

As VA adapts to changing health care markets and an aging veteran population, it recognizes the need for accurate information on the cost of providing and purchasing nursing home care, the availability of nursing home beds in local markets, and the adequacy of VA reimbursement rates to purchase quality nursing home care for veterans. Although VA has initiated efforts to improve its data in these areas, better information is still needed for VA to make informed resource management decisions.

Background

Veterans aged 65 or older are increasing both in number and in the percentage of the veteran population receiving VA health care services. More significantly, the number of veterans aged 75 and older, the heaviest

users of nursing home care, is increasing rapidly. VA estimates that the number of veterans aged 75 and older will increase from about 2.6 million in 1995 to about 4.0 million in 2000.

All veterans with a medical need for nursing home care are eligible to receive such care in VA nursing homes and community nursing homes under contract to VA. VA also pays a portion of the cost of care for veterans served in state veterans nursing homes.[3] Because most veterans receive care financed through other government programs (Medicare or Medicaid), private insurance, or personal assets, however, these VA programs provide only a portion of the nursing home care that veterans receive.

VA serves veterans essentially on a first-come, first-served basis up to the limits of VA's budget authority for nursing home care. VA is authorized to pay for care in community nursing homes for a period generally not longer than 6 months for nonservice-connected veterans and for an indefinite period for veterans with service-connected conditions. No maximum service period exists, and only higher income, nonservice-connected veterans must contribute to the cost of their care in VA nursing homes. State veterans homes establish their own admissions policy, and, although they receive per diem payments from VA, state homes generally rely on patient cost sharing to help cover expenses. VA operates 129 VA nursing homes (in 45 states), contracts with 3,766 community nursing homes (in all 50 states, the District of Columbia, and Puerto Rico), and pays a portion of the costs for veterans served in 80 state veterans homes (in 38 states).

Obligations for VA and state veterans nursing homes have increased each year from 1985 through 1995; obligations for community nursing homes have fluctuated over the same period. Overall, VA reports that nursing home obligations have grown from about $710 million in 1985, serving 72,889 veterans, to $1.6 billion in 1995, serving 79,373 veterans as shown in table 1.

[3]The daily amount paid per veteran in recognized state veterans homes is the per diem rate established by 38 U.S.C. 1741, for nursing home care. State veterans homes originated in the post-Civil War era when the federal government established homes for disabled soldiers in need of hospital and domiciliary care. The government could not meet the demand for services, and care was limited to veterans who had served with the Union Army. As a result, states established state homes for the care of soldiers at state expense. The Congress enacted legislation in 1888 authorizing the payment of $100 per year to help defray state tax burdens.

Table 1: VA Nursing Home Programs: Obligations and Utilization, 1985-95

	VA nursing homes		Community nursing homes		State veterans homes		Total
Fiscal year	Obligations	Veterans treated	Obligations	Veterans treated	Obligations	Veterans treated	Obligations
1985	$390,432,000	20,442	$268,936,000	38,907	$50,217,000	13,540	$709,585,000
1986	452,397,000	23,940	301,844,000	41,124	51,307,000	13,914	805,548,000
1987	492,810,000	25,567	325,677,000	41,925	54,293,000	14,116	872,780,000
1988	534,514,000	27,220	353,484,000	42,232	65,643,000	14,224	953,641,000
1989	598,588,000	26,561	281,487,000	32,209	70,248,000	14,311	950,323,000
1990	666,523,000	27,067	273,708,000	28,851	79,445,000	15,108	1,019,676,000
1991	766,521,000	28,376	288,031,000	28,450	85,346,000	15,319	1,139,898,000
1992	881,579,000	30,404	283,771,000	25,062	100,314,000	15,956	1,265,664,000
1993	966,561,000	31,668	332,564,000	26,887	114,270,000	16,849	1,413,395,000
1994	1,102,301,000	30,926	359,680,000	29,096	137,349,000	17,873	1,599,330,000
1995	$1,101,850,000	33,061	$360,759,000	26,971	$165,946,000	19,341	$1,628,555,000

To control construction of VA nursing homes and encourage placement of veterans in less costly community nursing homes, the Office of Management and Budget (OMB) established guidelines in 1987 for both the market share (16 percent) of the estimated demand by veterans for nursing home care and the distribution of veterans in the various types of facilities.[4] The patient distribution goal is 30 percent in VA nursing homes, 40 percent in community homes, and 30 percent in state veterans homes.

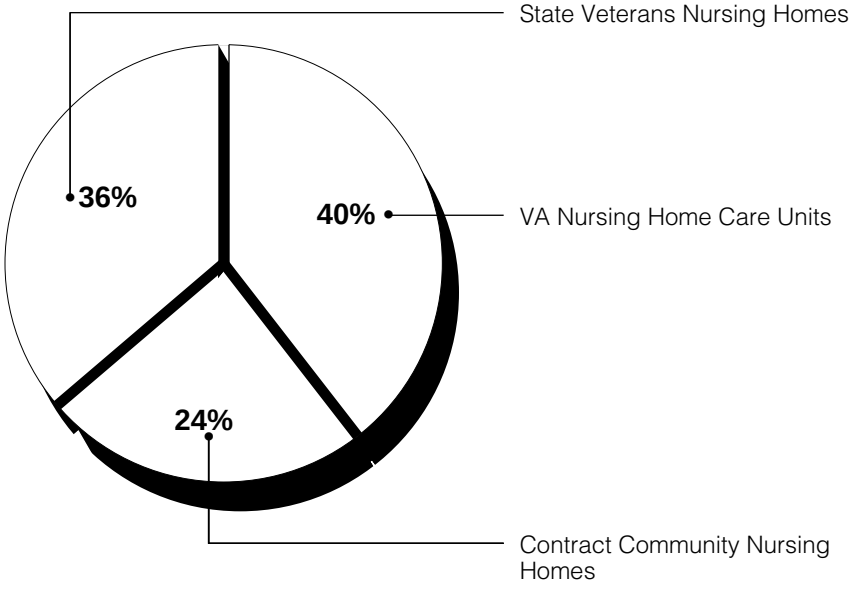
Management of nursing home resources in VA is changing with the reorganization of the VA health care system. The reorganization involves trimming unnecessary management layers, consolidating medical services, and using more community resources. Called the Veterans Integrated Service Network (VISN), the reorganized VA health care system will be administered and provided through 22 local network service areas and encompass the assessment, planning, and budgeting aspects of providing VA nursing home care in each service area. Implementation of the VISN will shift nursing home resource management decisions from individual VA medical centers to VISN directors. VA's transition to the VISN was in its early stages at the time of our review.

[4]These guidelines were announced in the President's fiscal year 1987 budget.

Patient Distribution in Types of Nursing Homes Has Shifted

The distribution of veterans in the three types of nursing homes differs greatly from VA's target of 30 percent in VA homes, 40 percent in community homes, and 30 percent in state homes. Figure 1 shows the distribution based on the average daily census[5] during fiscal year 1995. Appendix I shows, by state, the number of nursing homes that VA uses and the average daily census by each type of facility in fiscal year 1995.

Figure 1: Average Daily Census of Veterans in the Three Nursing Home Programs, FY 1995

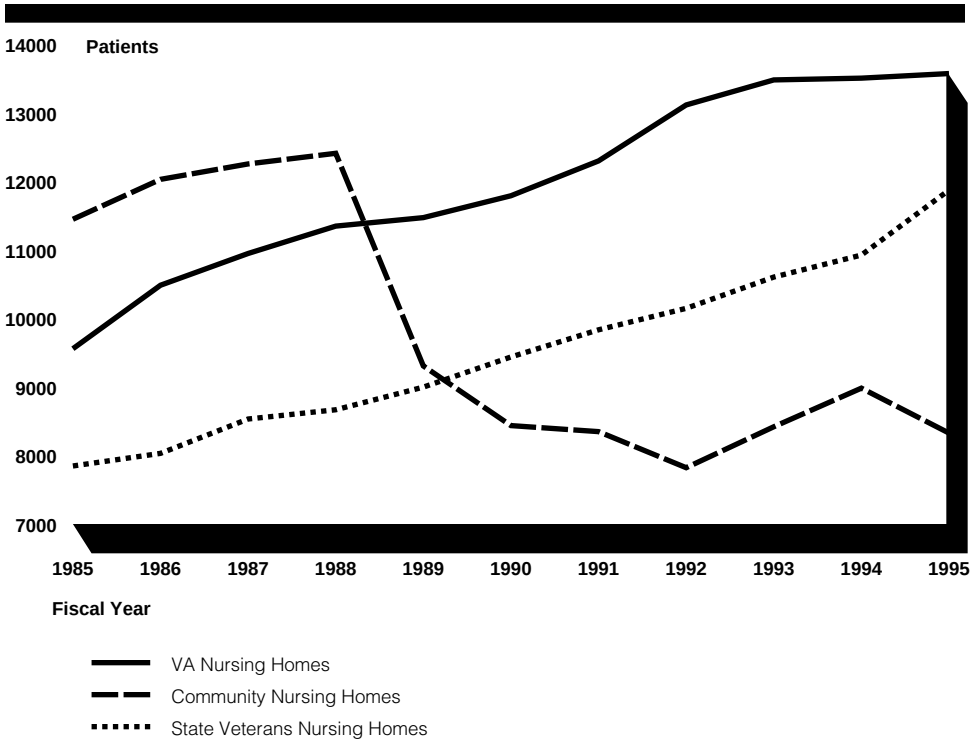


The distribution pattern has also shifted considerably over the years. In fiscal year 1985, for example, about 40 percent of veterans (figure based on the average daily census) receiving VA-financed or -provided nursing home care were cared for in community nursing homes. Also, VA's average daily census in community nursing homes was over 3,000 patients greater in 1985 than in 1995.[6] Figure 2 shows the average daily census in the three types of nursing homes from fiscal years 1985 through 1995.

[5]The number of patient days during the fiscal year divided by the number of days in the fiscal year.

[6]On the basis of patients treated, community nursing homes served about 12,000 more veterans in fiscal year 1985 than in fiscal year 1995.

Figure 2: Average Daily Census in Three Types of Nursing Homes, FY 1985-95



The distribution shift was the result of major reductions in expenditures for community nursing homes that occurred in the late 1980s and early 1990s. For example, in 1989 VA delegated community nursing home budget decisions to VA medical centers. Some medical center directors left their programs intact, while others used community nursing home funds for other medical center activities. Most community nursing home programs shrank considerably. According to a VA official, in fiscal year 1990, VA reversed its decision to delegate budget authority to medical centers because VA medical centers did not support the community nursing home program. VA's use of community nursing homes has not returned to pre-1989 levels, however. From fiscal years 1988 to 1993, the average number of community nursing homes under contract to each VA medical center decreased from 24 to 21, and the average number of veterans placed in community homes by each VA medical center decreased from 183 to 129.

Community nursing home funds have also been used to meet VA budget emergencies and to fund VA-sponsored noninstitutional care programs. According to VA budget documents, in fiscal year 1992, $35 million of VA's community nursing home program budget was reprogrammed to meet the increased costs of special pay rates for physicians and dentists. According to a VA official, the reprogramming of these funds was cleared by OMB and VA appropriations committees. Also, in fiscal year 1993, VA's Homemaker and Day Care programs, alternatives to institutional care, began to share community nursing home budget resources. This action was also supported by the Congress through language in VA's appropriations bill designed to increase VA's use of long-term care alternatives.

VA's Nursing Home Cost Data Are Incomplete

For fiscal year 1995, VA obligated $1.1 billion for VA nursing home operations, about $361 million for community nursing homes, and about $166 million for state veterans homes. According to VA-reported costs for fiscal year 1995, VA's daily patient cost was $213.17 for veterans in VA nursing homes, $118.12 for veterans in community nursing homes, and $35.37 for veterans in state veterans homes (where only a portion of costs are funded by VA). Actual costs are unknown, however, because VA data systems neither reflect all costs nor captured all costs in a consistent way to make accurate cost comparisons.

We have reported that VA's cost accounting system distributes costs inconsistently and is generally not reliable as a source for precisely comparing VA program costs.[7] We have also noted that VA cost reports are not subject to audit and rely on each medical center to determine the distribution of costs among different activities. VA budget and program officials we contacted recognize that cost reports do not provide useful, reliable cost information.

Because decisions on staff allocation costs and, in some cases, workload are made at the facility level, data are inconsistent among facilities. For example, VA's cost data do not include the cost of all services provided to community nursing home patients by VA medical centers, such as radiology and laboratory services, clinical visits, and medications. In addition, VA's costs for transporting veterans between community nursing homes and VA medical centers for treatment are generally excluded from VA's cost data for community homes. The inconsistent distribution of costs among VA

[7]VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995); Budget Issues: Financial Reporting to Better Support Decision-Making (GAO/AFMD-93-22, June 1993); Financial Management Issues (GAO/OGC-93-4TR, Dec. 1992).

cost centers leads to both overallocation and underallocation of overhead and variable costs (such as laundry, linen, janitorial, and administrative services) to VA nursing home units. Information was not available to determine the overall effect of cost distribution inconsistencies on VA nursing home daily costs.

Factors that contribute to cost differences between VA and community nursing homes include patient case mix differences and more intensive staffing patterns in VA homes than in community nursing homes. For example, VA's Nursing Home Cost Study issued in August 1996[8] reported that among patients sampled as of October 1, 1995, about 16 percent of VA nursing home patients were in a heavy care category[9] requiring special rehabilitation services (thus requiring more care and higher costs) compared with 3 percent of community nursing home patients. Conversely, more community nursing home patients were in a less resource-demanding category—22 percent for community nursing home patients compared with 17 percent for VA nursing home patients.

The study also noted that VA nursing homes have an overall higher level of staffing than community nursing homes (.69 patient care personnel per resident at VA facilities compared with .58 at community nursing homes) and that facilities have different types of staff.[10] RNs make up 36 percent of the staff at VA nursing homes but only 12 percent at community nursing homes. Aides, on the other hand, make up 67 percent of the staff at community nursing homes but only 32 percent of the staff at VA facilities.

In July 1995, VA began implementing a decision support system (DSS) at 38 hospitals. Current VA plans call for the deployment of DSS to all VA hospitals by fiscal year 1998. Such support systems in the private sector have proved to be an effective management tool for improving quality and cost-effectiveness, and VA expects DSS to do the same for its health care operations. DSS can compute the cost of services provided to each patient by combining patient-based information on services provided with

[8]The study was conducted by the Health Services Research and Development Service through VA's Management Decision and Research Center.

[9]These categories are based on Resource Utilization Group System-III (RUGS-III) classifications. RUGS-III is a classification system that categorizes nursing home residents according to their care needs (type, intensity, frequency, and so forth). The system is used to evaluate staffing and to determine some states' Medicaid reimbursement rates on the basis of case mix and resource utilization.

[10]Nursing homes have no recognized staffing standards. However, the Omnibus Budget Reconciliation Act of 1987 requires nursing facilities to have a licensed nurse on duty 24 hours a day; an RN on duty at least 8 hours a day, 7 days a week; and an RN director of nursing. (The director and the RN on duty may be the same person.)

financial information on the costs and revenue associated with those services. VA expects DSS to provide VA managers and health care providers with variance reports identifying areas for reducing costs and improving patient outcomes and clinical processes.

In a September 1995 report on the implementation of DSS,[11] we noted that VA had not developed a business strategy for effectively using DSS as a management tool. We also noted that VA had not yet developed business goals and associated plans to guide the organization, determine the proper location and use of resources, and provide a framework for using management tools such as DSS. VA is developing business plans that should be completed by December 1996. For example, one VISN work group charged with developing the network's long-term care business plan was directed by the VISN leadership to consider consolidating, contracting, or closing of all VA nursing homes in the service area. These options are being considered so that VA can effectively provide nursing home resources in future years to the aging veteran patient population.

Several Factors Affect VA's Use of Community and State Nursing Homes

VA's use of community nursing home beds is affected by (1) a shortage of beds in some parts of the country, (2) veteran and family preferences to use VA nursing homes, and (3) VA's inability to compete with other purchasers of community nursing home services in some locations because of lower reimbursement rates. VA has several initiatives under way to improve its access to community nursing home beds by improving the competitiveness of its rates but needs better information on specific locations where rate adjustments would be appropriate. On the other hand, VA's use of state veterans nursing homes is limited because of the number of such beds available and because VA has little control over who gets admitted to these facilities.

Availability of Community Nursing Home Beds Varies

The availability of nursing home beds and occupancy rates are critical to VA's ability to place veterans in community nursing homes. According to a 1996 study by the Institute of Medicine (IOM), Nursing Staff in Hospitals and Nursing Homes, the demand for nursing home services continues to grow as the number of aged and chronically ill people increases. IOM reported that in most areas of the country, the demand for nursing home services has surpassed the supply of beds, especially in relation to the growth in the oldest of the elderly population. In 1990, the United States had approximately 32 million people aged 65 years or older. This number

[11]GAO/AIMD-95-182, Sept. 29, 1995.

is projected to double by 2030. The number of elderly needing nursing home care is expected to triple from about 1.8 million in 1990 to about 5.3 million in 2030. The median occupancy rate for U.S. nursing facilities was about 93 percent in 1994, the most current year for which data were available.

As demand for nursing home resources grows, VA's access to community nursing home beds varies by community. VA has identified seven geographic areas where it has problems securing community nursing home beds: California, the District of Columbia, Florida, New Hampshire, New York, South Carolina, and Virginia. In other parts of the country, though, VA does not appear to have such problems. According to our questionnaire respondents, for example, the availability of community nursing home beds in Oklahoma City, Oklahoma, and Kansas City, Missouri, exceeded the number of veterans needing beds. A VA planning official in Salt Lake City, Utah, also mentioned that this service area has always had a large number of community nursing home beds available.

To make informed nursing home resource management decisions, VA needs reliable demand and capacity data. The VA Inspector General and we have criticized VA for consistently undercounting available community beds and not basing its nursing home construction or expansion projects on reliable data.[12] VA has in fact overstated its nursing home construction needs. For example, we noted in August 1995 that VA's planned conversion of the former Orlando Naval Hospital to a nursing home and the construction of a new hospital and nursing home in Brevard County were not the most prudent and economical uses of its resources. Furthermore, we noted that VA could purchase care from community nursing homes to meet veterans' needs more conveniently and at a lower cost.

The VA Inspector General noted in 1994 that regional planners had excluded suitable and available community nursing home beds and used questionable community data in needs assessments. Regional planners indicated that they lacked staff resources to validate community resource data or reasonably establish that the data were reliable or accurate. It is not yet clear how the VISN structure will address the need to improve the reliability of community resource data on available community nursing home beds.

[12]VA Health Care: Improvements Needed in Nursing Home Planning (GAO/HRD-90-98, June 12, 1990); Veterans Health Administration's Nursing Home Care Program Resource Management and Planning, VA, Office of the Inspector General, Report No. 4R3-17-109 (Washington, D.C.: Aug. 31, 1994); VA Health Care: Need for Brevard Hospital Not Justified (GAO/HEHS-95-192, Aug. 29, 1995).

Veterans and Families Often Prefer VA Nursing Homes

A May 1995 VA report, Evaluation of the Enhanced Prospective Payment System (EPPS) for VA Contract Nursing Homes, states that many longer stay patients were in a VA nursing home because they or their families refused to allow their admittance to a community facility. Veterans and their families were concerned about the limited VA benefit in community homes (6 months for nonservice-connected veterans) and the depletion of assets that occurs before a veteran's community nursing home care is converted to Medicaid.[13] Also, many veterans tend to prefer to be housed with other veterans because community nursing homes lack the (mainly male-oriented) culture of VA or state veterans homes.

VA Reimbursement Rates May Limit Access to Community Nursing Homes

VA studies suggest that VA's reimbursement rates may be too low in some areas, and as a result veterans' access to community nursing homes may be limited. VA has initiatives under way to enhance access to community nursing homes but needs better information to determine where reimbursement rates adversely affect veterans' access to these homes.

VA pays facilities a fixed daily rate for nursing home services. This rate is intended to cover all necessary services, both routine daily services (room, board, and nursing services) and special and ancillary services (primary and specialty physician services, diagnostic tests, and equipment).[14] The rate is based on each state's daily Medicaid rate for basic nursing home care, plus an additional 15 percent. VA medical centers may negotiate with community nursing homes to provide higher reimbursements for extra care cases (that is, costly special and ancillary services).[15]

Other payers, such as private insurers, Medicare, and Medicaid, generally do not reimburse community nursing homes on a daily-rate basis. The nursing home market generally reimburses on a unit-of-service basis. For example, the Medicaid program allows providers to bill for medical services, such as physician care and diagnostic tests, on a unit-of-service basis.

[13]To be eligible for Medicaid, nursing home residents must have income and assets below eligibility thresholds.

[14]The Veterans Health Administration's (VHA) payment method has been altered to allow direct payment of drug costs that exceed 7.5 percent of the per diem. In addition, therapy costs up to 60 percent of per diem can be paid by a VA medical center without requesting an exemption.

[15]Providers are precluded from billing other third-party payers for costs incurred beyond the VA contract rate. Both VA and HHS consider this double billing. VA does permit a provider to bill Medicare for hospice and dialysis services.

In some communities, VA reimbursements are not competitive with other payers. Community nursing home administrators in the facilities we visited informed us that VA was not paying what was necessary to care for some veterans, particularly those patients with heavy care needs. For example, an administrator of a Salt Lake City home indicated that although VA's contract rate is adequate for most patients, it is inadequate for patients on intravenous or feeding tubes. Another administrator in Richmond, Virginia, indicated that although the nursing home has the capacity to admit additional veterans, it would turn away veterans requiring heavy care involving high treatment costs because VA's reimbursement is inadequate. Nursing home administrators and VA questionnaire respondents told us that veterans with behavioral problems, alcohol or drug dependencies, or conditions requiring the use of a ventilator were most likely to be refused admission to a community nursing home.

Nursing home administrators said that they make trade-offs between serving veterans at potentially lower reimbursement rates and serving private pay, Medicare, and Medicaid patients whose ancillary service costs can be billed separately. The 1993 National Survey of VA Community Nursing Home Program Practices conducted by VA's Midwest Center for Health Services and Policy Research noted that only 29 percent of VA medical centers indicated that the Medicaid plus 15 percent reimbursement rate was adequate to cover community nursing home costs in their area.

VA policy allows medical centers to negotiate reimbursement rates higher than the standard Medicaid plus 15 percent rate, and VA's May 1995 Evaluation of the Enhanced Prospective Payment System noted that 20 percent of community nursing homes were paid higher rates. Some VA medical centers do not pursue higher rates because negotiating contracts is burdensome and obtaining approval for such rates from the VA regional level sometimes takes 2 to 4 months. The study concluded that these increasingly difficult negotiations sometimes soured relations with community nursing homes. As a result of the study, VA changed its policy on community nursing home rate exceptions, allowing local VA medical center director approval, except for subacute care.

In addition, VA is a small purchaser of nursing home care in most markets, providing little incentive for nursing homes to engage in lengthy negotiations. For example, in May 1995, VA's Management Decision and Research Center noted that no veterans were placed in one-quarter to one-third of the community nursing homes with which VA had contracts

during fiscal years 1988 through 1994. The remaining homes under contract during that period had between 4.6 and 6.3 veterans placed per year on average.

VA Has Three Initiatives to Enhance Access to Community Nursing Homes

VA is trying to improve the competitiveness of its nursing home reimbursement rates through three initiatives: (1) multistate contracting, (2) a prospective payment system based on Medicare nursing home reimbursement rates, and (3) revisions to the standard community nursing home contract format. However, VA needs better information to identify specific locations where adjustments to reimbursement rates are needed to enhance access to community nursing home beds.

In September 1995, VA issued a request for proposals for multistate contracts to provide nursing home services. Multistate contracting is intended to enhance VA's ability to access beds by easing the administrative requirements on community nursing homes and offering prospective providers a large volume of patients. VA plans to commit $34 million to these contracts or about 10 percent of the community nursing home program budget. The multistate contracts specifically guarantee access for veterans up to the amount specified in the contracts.

VA awarded six multistate contracts to private corporations on September 1, 1996, and also contracted with a provider with 20 facilities in California. The new contracts will provide VA access to 1,101 nursing homes in 43 states, and VA believes the contracts offer administrative and other cost efficiencies. Each corporation will provide five levels of care based on a state-specific pricing structure designed to achieve cost savings over the life of the contract.

Since 1991, VA has also been pilot testing a prospective payment system based on Medicare reimbursement rates. EPPS, implemented in 8 of VA's 164 medical centers with nursing homes or contracts with community nursing homes, provides three levels of reimbursement—superskilled, skilled, and intermediate-level care. Ancillary costs are also included in these rates, but speech, physical, and occupational therapies are reimbursed separately using rates established by VA's central office. A 1995 study by VA's Management Decision and Research Center estimated that the pilot system reimbursed nursing homes $3,402 more per patient than VA's normal reimbursement system. However, while data limitations made it inconclusive, the study suggested that these added costs were outweighed by savings to VA medical centers from moving patients from the hospital

sooner to nursing homes, which provide a lower (and less expensive) level of care.

VA will use the findings of the EPPS evaluation to collect information on nursing home market conditions and hospital utilization to determine whether special efforts are needed to become more competitive in community nursing home markets. VA medical centers may qualify to participate by meeting certain criteria based on cost, access, and administrative workload considerations. For example, medical centers will be allowed to participate if more than 50 percent of their community nursing home contracts require exceptions to the Medicaid plus 15 percent reimbursement rate. Other participation criteria include the inability to place more than 5 percent of patients who are considered appropriate for nursing home placement and a caseload that includes more than 50 percent of patients who need specialized care and require special negotiations before placement.

In June 1995, VA changed its standard nursing home contract to provide for multiple reimbursement rates. These rates include the following categories of care: (1) reduced physical function, (2) basic, (3) heavy rehabilitation therapy, (4) special care, (5) clinically complex, (6) ventilator dependent, (7) human immunodeficiency virus/acquired immunodeficiency syndrome, and (8) Clinitron[16] dependent. Rates are figured using the current Medicaid rate plus an amount to cover the use of additional supplies, services, and equipment associated with each category of care.

Although these initiatives should improve VA's access to community nursing home beds, VA needs reliable information on the availability of community nursing home beds and the reasons for access problems in specific locations to make informed decisions about where adjustments to reimbursement rates are warranted. Without information on the reasons for access problems in specific locations, assertions of noncompetitive VA reimbursement rates could obscure medical center preferences for using VA nursing homes. Some of the information available is anecdotal and based on testimonial rather than quantitative evidence. For example, a 1993 VA Inspector General report on the EPPS pilots noted that two sites reported that the pilot rates were too high for their area, though the pilot sites had been selected because they had reported difficulty accessing community nursing home beds. The Inspector General noted that the higher reimbursement rates did not ensure placement of "heavy care"

[16]Specially designed beds that feature a constantly circulating silicon mattress. The bed is used to treat and prevent decubitus ulcers (bed sores).

(costly) VA patients in exchange for the higher costs associated with the pilots.

Admission to State Veterans Homes Controlled by States

VA's access to state veterans homes is also limited. States establish admission policies, which vary from state to state. In some instances, admission criteria for state veterans homes are more restrictive than VA admission criteria. For example, some state homes require that veterans have service-connected disabilities or wartime military service. Other states allow admission of veterans' spouses and other nonveterans. Bed availability in state homes also helps determine VA's ability to use these facilities. For example, according to discussions we had with state nursing home admissions staff in fiscal year 1996, Massachusetts has a waiting list for skilled care bed admissions in its two state facilities; Colorado, however, has no waiting list for its four facilities and admits nonveterans to all four homes.

Quality of Care Varies Among Nursing Homes

VA and we have found differences in the quality of care provided by the various types of nursing homes. Through its monitoring efforts, VA works with homes to improve patient care. On the basis of our review of selected quality indicators, the homes we visited appeared to provide comprehensive and appropriate care to veterans. VA homes, however, generally had fewer quality-of-care issues than most of the community and state homes we saw.

VA requires its medical centers to ensure that veterans receive quality care in any nursing facility in which they are placed. Specifically, on a monthly basis, VA medical centers must send an RN or social worker to visit veterans in community nursing homes to review their care and to provide a liaison between the community home and the VA medical center. An RN must visit patients at least every other month. Medical center staff also review state survey and certification data maintained for Medicare- and Medicaid-certified facilities. They also review Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditations, when available, to assess community nursing homes' compliance with appropriate standards. In addition, VA medical centers conduct annual on-site evaluations of community facilities using a multidisciplinary team to review patient records, policy, and procedures and to check fire and safety provisions.

VA annually inspects state veterans homes to certify their eligibility for per diem payments by meeting VA standards of care. VA inspections of state nursing homes are carried out by medical center staff and are similar to annual inspections of community nursing homes. If the medical center determines that care is inappropriate, it can suspend per diem payments for veterans placed in state homes.

VA Homes Had Fewer Quality-of-Care Issues Than Other Types of Homes

We visited 2 VA, 10 community, and 5 state veterans nursing homes, where we reviewed the care provided to 95 veterans. The patients were randomly selected for a representative sample at the VA and state veterans homes. We reviewed the total veteran population under VA contracts at each community home but did not review the care provided to nonveteran patients in these facilities. We used the 1995 HCFA Provider Certification Survey Procedures to assess the quality of care and the overall ability of the facility to meet patient care needs.

Patient care in the two VA nursing homes we visited was comprehensive and generally met Medicare certification standards. One VA nursing home had achieved 100-percent participation in patient therapies. VA nursing homes are hospital based and therefore have greater access to rehabilitative and restorative services than other nursing homes. In addition, VA nursing homes were generally staffed by a higher number of RNs, gerontological and rehabilitation specialists, social workers, and physical therapists than community and state veterans homes, and all VA nursing homes are JCAHO accredited.

Although care met quality standards, we found some quality-of-care issues at all 10 community nursing homes we visited. For example, we noted that veterans in some community homes were less likely to receive ongoing restorative therapies than in VA facilities. We also noted that community nursing homes used physical and chemical restraints more often than VA homes we visited. One facility was not certified for Medicare or Medicaid, and one rural facility had only recently qualified for Medicare certification by ensuring that at least one RN staffed the facility 8 hours every day. None of the community facilities we visited was JCAHO accredited.

Although medical center staff did not always comply with monthly on-site monitoring requirements because of resource limitations, they generally visited community nursing home patients when problems were identified. At one location, medical center staff told us they were reluctant to criticize community nursing homes because bed availability was at a premium and

they did not want to antagonize the homes. The staff at this medical center did perform monthly monitoring visits and sought to resolve patient care problems by educating facility staff and providing patient care consultations. According to our survey respondents, VA medical centers terminated 50 contracts with community nursing homes in fiscal year 1994 because of quality-of-care problems. No placements were made in an additional 67 contract facilities because of quality-of-care concerns during the same time frame.

VA's study of EPPS also noted that some patients received insufficient medications and restorative or rehabilitative care in community nursing homes. The report cited one group of community nursing home providers who said distinct differences existed in the quality of care provided to private and Medicare patients compared with Medicaid and VA patients.

Care provided in the state homes we visited generally met quality standards. One state home, however, had several quality-of-care issues. The home was not certified for Medicare or Medicaid or accredited by JCAHO. This home showed little evidence of planned daily activity and did little to protect the privacy of patients, whose care was provided in open wards without privacy curtains. We also observed heavy use of physical and chemical restraints at this facility. Although the VA medical center knew about this facility's problems and annual visits had detected long-standing problems, the medical center's infrequent attention to the facility's quality-of-care problems was not sufficient to effect corrective measures.

Conclusions

The uneven distribution of nursing homes and differences in the extent to which VA reimbursement rates are competitive in local markets could reasonably lead to different responses among VA networks to meet the demand for cost-effective, high-quality nursing home services. However, without (1) accurate and complete information on nursing home costs, (2) better information on the availability of community nursing home beds, and (3) information on the competitiveness of VA reimbursement rates, VA has inadequate assurance that it is using the nursing home resources at its disposal to the best of its ability to serve veterans in need of such care. As VA implements the VISN structure, decisionmakers will need better cost- and care-based information on the nursing home services it provides or purchases.

VA's implementation of multistate contracts and efforts to improve the competitiveness of its reimbursement rates should improve its access to community nursing home beds. VA's efforts to more accurately identify and report nursing home costs through DSS are incomplete. Also, VA needs better information on the availability of community nursing home beds and must identify locations where current rates are not competitive, especially in areas not covered by multistate contracts.

Recommendations

As part of VA's ongoing efforts to improve nursing home resource management decisions, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to more accurately accumulate and report nursing home costs, assess the availability of community nursing home resources, and identify locations where current reimbursement rates are not competitive.

Agency Comments and Our Evaluation

On November 25, 1996, we met with the Assistant Chief Medical Director for Geriatrics and Extended Care and other VA officials to obtain their comments on a draft of this report. The VA officials stated that the report complements VA's efforts to review options for providing long-term care for veterans and concurred with our findings and recommendations. VA is currently rethinking its nursing home patient distribution goals for the three types of facilities and is also considering greater emphasis on alternatives to long-term care for veterans such as home and community health care, day care, and other noninstitutional care options. To this end, VA has established an Advisory Committee on the Future of VA Long-Term Care, which will make recommendations to VA's Under Secretary for Health on the scope and structure of VHA's long-term care services and the changes necessary to ensure that services for veterans are available and effective in future health care settings. Committee members will be selected on the basis of professional expertise in various components of long-term care and will represent constituencies such as veterans service organizations, nursing home corporations, and university-based academic communities. VA expects recommendations from the committee in 1-1/2 to 2 years.

VA agreed that its Cost Distribution Report is inadequate, and although better information on costs and local resources is available from data collected in conjunction with the new multistate contracts, VA still expects that full implementation of DSS will improve data on costs and patient outcomes. In addition, VISN networks have been provided a new

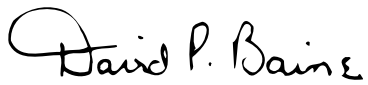
population-based, long-term care planning model that is being used to develop network business plans.

VA noted that it has initiated efforts to improve collection of data on community nursing home patients to compare their characteristics (including case mix) with VA nursing home patients. A Patient Assessment Instrument, now used for VA nursing home patients, will be applied to community nursing home patients and is currently used for patients referred to multistate contract facilities. VA also offered several technical comments and clarifications on our draft report that we incorporated into the final report as appropriate.

Copies of this report are being sent to the Secretary of Veterans Affairs, other congressional committees, and interested parties. Copies will be made available to others upon request.

Please call me at (202) 512-7101 if you have any questions or need additional assistance. Other GAO contacts and staff acknowledgments to this report are listed in appendix II.

Sincerely yours,



David P. Baine
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Abbreviations

DSS	decision support system
EPPS	Enhanced Prospective Payment System
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OMB	Office of Management and Budget
RN	registered nurse
RUGS-III	Resource Utilization Group System-III
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Number of Nursing Home Facilities and Average Daily Census in Fiscal Year 1995

	Number of facilities			Average daily census			
State	NHCU[a]	CNH[b]	SVH[c]	NHCU	CNH	SVH	Total
Alabama	2	83	3	316	81	188	580
Alaska	0	10	0	0	12	0	12
Arizona	3	35	0	214	165	0	379
Arkansas	1	55	1	175	106	58	339
California	8	170	1	961	776	423	2,160
Colorado	3	31	4	235	83	234	552
Connecticut	1	26	0	76	108	0	184
Delaware	1	10	0	59	26	0	85
District of Columbia	1	1	0	115	0	0	115
Florida	6	217	1	889	342	96	1,327
Georgia	3	116	2	271	277	497	1,045
Hawaii	0	10	0	0	15	0	15
Idaho	1	17	3	33	20	266	319
Illinois	4	119	4	649	552	909	2,110
Indiana	3	136	1	170	140	304	614
Iowa	1	86	1	239	68	461	768
Kansas	3	40	1	254	103	64	421
Kentucky	1	58	1	79	95	240	414
Louisiana	2	111	1	182	151	139	472
Maine	1	29	4	84	30	216	327
Maryland	2	47	1	123	120	252	495
Massachusetts	3	119	2	391	412	266	1,069
Michigan	5	82	2	438	144	673	1,255
Minnesota	2	144	3	296	169	441	906
Mississippi	2	64	1	167	114	144	425
Missouri	3	65	5	193	223	636	1,052
Montana	1	53	2	29	44	88	158
Nebraska	1	39	4	54	65	484	603
Nevada	1	44	0	55	23	0	78
New Hampshire	1	25	1	108	32	136	276
New Jersey	2	14	3	283	83	715	1,081
New Mexico	1	29	2	44	55	158	257
New York	11	180	4	1,311	513	656	2,479
North Carolina	4	109	0	312	218	0	530
North Dakota	1	18	1	46	18	33	97
Ohio	4	163	1	717	405	313	1,435
Oklahoma	0	49	6	0	96	1,019	1,115

(continued)

	Number of facilities			Average daily census			
State	**NHCU[a]**	**CNH[b]**	**SVH[c]**	**NHCU**	**CNH**	**SVH**	**Total**
Oregon	2	68	0	198	155	0	353
Pennsylvania	9	169	4	1,137	449	544	2,130
Puerto Rico	1	4	0	98	8	0	106
Rhode Island	0	17	1	0	69	241	310
South Carolina	1	91	2	118	101	287	506
South Dakota	2	44	1	152	47	36	235
Tennessee	3	110	1	336	231	108	675
Texas	9	236	0	937	563	0	1,500
Utah	0	34	0	0	79	0	79
Vermont	1	13	1	24	24	150	198
Virginia	3	74	1	267	177	164	608
Washington	3	93	2	160	179	328	667
West Virginia	2	87	0	180	218	0	398
Wisconsin	2	114	1	320	127	511	958
Wyoming	2	8	0	77	23	0	100
Total	**129**	**3,766**	**80**	**13,572**	**8,334**	**12,478**	**34,384**

[a]Nursing home care unit refers to a VA nursing home.

[b]Community nursing home.

[c]State veterans home.

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