

United States Senate
WASHINGTON, DC 20510

May 5, 2020

The Honorable Gene Dodaro
Comptroller General of the United States
Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Dodaro:

With the recent spike in veteran deaths and other reported care deficiencies at State Veterans Homes (SVHs)¹ across the nation during the coronavirus disease 2019 (COVID-19) pandemic, we write to request the Government Accountability Office (GAO) conduct a review of the oversight by the U.S. Department of Veterans Affairs (VA or the Department) of all State Veterans Homes' quality of care.

We also request that the review include an update on the progress VA has made in implementing GAO's recommendations issued in July 2019 for VA to improve its oversight of State Veterans Homes and the transparency regarding its assessments of these facilities.² Currently, the three GAO recommendations related to the VA's oversight of State Veterans Homes remain open.³ The recent deaths of veteran residents and other care challenges at State Veterans Homes during the COVID-19 public health emergency remind us that VA's

¹ WWLP22 News, "Another veteran passes away, 84 deaths total at Soldiers' Home in Holyoke," WWLP Staff, May 3, 2020, <https://www.wwlp.com/news/local-news/hampden-county/another-veteran-passes-away-84-deaths-total-at-soldiers-home-in-holyoke/>; NorthJersey.com, "Commissioner of NJ veterans homes where 103 have died of coronavirus resigns," Scott Fallon, April 28, 2020, <https://www.northjersey.com/story/news/coronavirus/2020/04/28/coronavirus-nj-commissioner-veteran-homes-103-died-resigns-menlo-paramus/3041664001/>; WSFA12 News, "8 residents die, dozens more test positive for COVID-19 at state veterans home," WBRC Staff, April 23, 2020, <https://www.wsfa.com/2020/04/23/residents-die-dozens-more-test-positive-covid-state-veterans-home/>; The Philadelphia Inquirer, "'It's a sinking ship': COVID-19 deaths triple at state-run vets nursing home in Chester County as families clamor for information," William Bender, Allison Steele, and Vinny Vela, April 25, 2020, <https://www.inquirer.com/news/southeastern-veterans-center-coronavirus-chester-county-covid-20200425.html>; San Antonio Express-News, "Two dead after COVID-19 strikes state veterans home in Floresville," Peggy O'Hare, April 22, 2020, <https://www.expressnews.com/news/local/article/Two-dead-after-COVID-19-strikes-state-veterans-15218682.php>.

² U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019, <https://www.gao.gov/products/GAO-19-428>.

³ U.S. Government Accountability Office, "Recommendations Database," https://www.gao.gov/reports-testimonies/recommendations-database/?rec_type=all_open&q=GAO-19-428&field=rptno_s#results (These results were produced after searching for GAO Report Number GAO-19-428.).

implementation of these recommendations would contribute toward improved care quality at these facilities nationwide and better inform veterans and their families about the best care options. While VA does not supervise or control the administration of State Veterans Homes, VA pays for veterans to receive care at these facilities and is the only entity that inspects every SVH in the nation. As long as VA is utilizing State Veterans Homes to provide care for veterans and pays for all or some of care costs in SVHs across the country, the Department should faithfully and efficiently implement GAO's recommendations and ensure veterans are receiving quality care.

State Veterans Homes are state-operated and managed facilities that provide nursing home, home (domiciliary), or adult day care to veterans,⁴ and they are the facilities where a majority of veterans receive nursing home care.⁵ While VA does not supervise or control the nation's 148 SVHs and they are all inspected either by state agencies or the Centers for Medicare & Medicaid Services (CMS), the Department is the only entity that "conducts annual inspections for all SVHs in order to assess compliance with VA standards,"⁶ and VA-recognized State Veterans Homes may receive financial contributions from the Department to help with costs of providing care to veterans.⁷ These inspections are important because they represent "a primary means through which VA oversees the quality of care provided to veterans at these facilities."⁸ In other words, VA has an important role in State Veterans Homes.

In July 2019, GAO conducted a review of nursing home care administered to veterans in three settings: community living centers (CLCs), community nursing homes (CNH), and State Veterans Homes (SVHs). The review included an examination of VA's use of inspections to assess the quality of care provided to veterans in SVHs, VA's oversight of the contractor upon which it relies to conduct the inspections, and the information that VA publicly provides on the quality of care at SVHs.⁹ While VA "collects VA prescribed quality measure and staffing data from SVHs," the Department does not assign them a quality rating.¹⁰ In its investigation, GAO stipulated that VA's contractor conducted the mandatory annual inspections of all SVHs, cited deficiencies, and took steps to help SVHs address those deficiencies.¹¹ However, GAO found that "VA has not monitored the SVH contractor's performance of these inspections through regular observational assessments to ensure that contractor staff effectively determine whether SVHs are meeting required standards."¹²

⁴ U.S. Department of Veterans Affairs, "Geriatrics and Extended Care – State Veterans Homes," https://www.va.gov/geriatrics/pages/State_Veterans_Homes.asp.

⁵ U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019, <https://www.gao.gov/assets/710/700142.pdf> ("SVHs accounted for the largest percentage (53 percent) of the average number of veterans who received nursing home care each day in fiscal year 2017.").

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019, <https://www.gao.gov/assets/710/700142.pdf>.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

Aside from referencing its limited oversight role, GAO noted that VA could not provide a legitimate reason for failing to regularly observe its contractor's inspections and does not maintain records of their observations.¹³ Accordingly, GAO concluded that VA's failure to observe its contractor's inspections of SVHs means "VA does not know whether, or to what extent, VA's contractor needs to improve its ability to identify SVHs' compliance with quality standards, which increases the possibility that quality concerns in some SVHs could go overlooked, potentially placing veterans at risk."¹⁴ Given that VA does not require its contractor to classify a State Veterans Home's failures to meet quality standards as deficiencies in care, "VA does not have complete information on deficiencies identified at SVHs and therefore cannot track this information to help identify trends in quality across these homes."¹⁵ Simply put, VA's inspections of SVHs need improvement.

Veterans and their families depend on complete and accurate information to determine the most appropriate nursing home setting (i.e., State Veteran Home, Community Living Center, or Community Nursing Home), and VA publicly provides quality of care information about Community Living Centers and Community Nursing Homes on its website.¹⁶ However, GAO found that VA "does not provide information on the quality of SVHs" on its website, despite "collect[ing] VA prescribed inspection, quality measure, and staffing data as part of its survey process that could be used to develop and distribute quality information for each home."¹⁷ Publishing this information online is important because it "could be the only readily accessible source of quality care information publicly available to veterans and their families for certain SVHs."¹⁸ There are no current limits to the Department's authority to publish this information on its website.¹⁹

Given these findings, GAO made three recommendations in its July 2019 report for VA regarding its role in State Veterans Homes: 1) devise a strategy to regularly monitor the performance of its contractors that inspect SVHs, and make sure their performance is documented and corrective actions at SVHs are taken; 2) require that VA's contractors classify as "deficiencies" in its SVH inspections all failures to meet VA's quality standards; and 3) publish information on the quality of care at all SVHs on VA's website.²⁰ VA agreed with these recommendations but thus far has not fully implemented them.²¹

¹³ U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019, <https://www.gao.gov/assets/710/700142.pdf>.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ U.S. Department of Veterans Affairs, "How Does Care Compare In VA and Other Facilities In My Area?," <https://www.accesstocare.va.gov/Healthcare/QualityOfCare>.

¹⁷ U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019, <https://www.gao.gov/assets/710/700142.pdf>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ U.S. Government Accountability Office, "VA Nursing Home Care – VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website," GAO-19-428, July 2019,

Given the importance of State Veterans Homes in VA's overall portfolio for providing institutional care to veterans and our ongoing concerns about VA's role monitoring states' operation of these facilities, we would like GAO to conduct a more detailed examination of VA's oversight of State Veterans Homes' quality of care and report on any progress in implementing recommendations from GAO's July 2019 report. Specifically, we request that GAO address the following questions:

1. What does available data reveal about the quality of care in State Veterans Homes? Where possible, please describe what VA data and data from other sources – such as states and the Centers for Medicare & Medicaid Services (CMS) – reveal about quality.
2. What is the role of VA and the role of the states in ensuring veterans receive quality care and how does VA ensure veterans are receiving quality care at State Veterans Homes? Do either the VA and/or states, have system to capture real time spikes in mortality rates and other quality of care metrics, so that immediate state or federal action can be taken to address these issues?
3. How do State Veterans Homes address identified quality concerns, including concerns raised in both VA and CMS inspections? What steps can VA take to address any quality concerns within State Veterans Homes? How can veterans and their families communicate issues regarding State Veterans Homes to VA?
4. How do VA Medical Centers coordinate with State Veterans Homes on the medical care that veterans residing in State Veterans Homes receive?
5. How does VA assist State Veterans Homes with emergency preparedness, and how can VA better support SVH emergency preparedness? What level of access to infection control resources do SVHs have (e.g. testing, personal protective equipment, staff, and expertise) and how can VA and states collaborate to improve access to such resources for SVHs?
6. To what extent has VA implemented GAO's recommendations in GAO-19-428 relating to its oversight role in State Veterans Homes?

Thank you for your attention to this matter. If you have any questions about this request, please contact the following staff: Feras Sleiman (Feras_Sleiman@warren.senate.gov), Brian Cohen (Brian_Cohen@warren.senate.gov), and Jonathan Rue (Jonathan_Rue@warren.senate.gov) for Senator Warren; Shauna Rust (Shauna_Rust@vetaff.senate.gov) for Senator Tester; Adam Axler (Adam_Axler@markey.senate.gov) and Sarah Trister (Sarah_Trister@markey.senate.gov) for Senator Markey; and Valli Sanmugalingam (Valli_Sanmugalingam@casey.senate.gov) for Senator Casey.

<https://www.gao.gov/assets/710/700142.pdf>; U.S. Government Accountability Office, "Recommendations Database," https://www.gao.gov/reports-testimonies/recommendations-database/?rec_type=all_open&q=GAO-19-428&field=rptno_s#results (These results were produced after searching for GAO Report Number GAO-19-428.).

Sincerely,

/s/

Elizabeth Warren
United States Senator

/s/

Jon Tester
United States Senator

/s/

Edward J. Markey
United States Senator

/s/

Robert P. Casey, Jr.
United States Senator