Supporting Statement for Per Diem for Nursing Home Care of Veterans in State Homes (38 CFR Part 51) and Per Diem for Adult Day Care of Veterans in State Homes (38 CFR Part 52) VA Forms 10-5588, 10-3567, 10-10SH, 10-0143, 10-0143a, 10-0144, 10-0144a and 10-0460 (OMB 2900-0160)

A. JUSTIFICATION

1. Explain the circumstances that make the collection of information necessary. Identify legal or administrative requirements that necessitate the collection of information.

Title 38, CFR Part 51, provides for the payment of per diem to State homes that provide nursing home care to eligible veterans. Title 38, CFR Part 52, provides for the payment of per diem to State homes that provide adult day health care to eligible veterans. The intended effect of these provisions was to ensure that veterans receive high quality care in State Homes. To ensure that high quality care is furnished veterans, VA requires those facilities providing nursing home care and adult day health care programs to veterans to supply various kinds of information. The information required includes an application for recognition based on certification; appeal information, application and justification for payment; records and reports which facility management must maintain regarding activities of residents or participants; information relating to whether the facility meets standards concerning residents' rights and responsibilities prior to admission or enrollment, during admission or enrollment, and upon discharge; the records and reports which facilities management and health care professionals must maintain regarding residents or participants and employees; various types of documents pertaining to the management of the facility; food menu planning; pharmaceutical records; and life safety documentation. VA Form 10-10EZ (OMB approval 2900-0091) is used in conjunction with the VA Form 10-10SH.

2. Indicate how, by whom, and for what purposes the information is to be used; indicate actual use the agency has made of the information received from current collection.

This information is necessary to ensure that VA per diem payments are limited to facilities providing high quality care. Without access to such information, VA would not be able to determine whether high quality care is being provided to eligible veterans.

3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g. permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.

To comply with the Government Paperwork Elimination Act, all forms in this group now appear on the One-VA Internet website in a fill and print mode which enables the user to electronically retrieve the latest version of a form, complete the form electronically, and save the filled form in *.pdf format. Once VA has developed an effective policy for electronic signature use and pending the availability of funds, we can begin the re-engineering process to allow electronic submission. The collection of information has been automated for internal fiscal and quality survey portions of data collection.

4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.

There is no duplication associated with this collection of information.

5. If the collection of information impacts small businesses or other small entities, describe any methods used to minimize burden.

The impact on small businesses and other small entitles is minimized by using "standard data" or data routinely maintained by health care facilities. The collection of information has been thoroughly analyzed to ensure that all requested data is essential.

6. Describe the consequences to Federal program or policy activities if the collection is not conducted or is conducted less frequently as well as any technical or legal obstacles to reducing burden.

If VA does not require this information, the Department would be unable to assess the quality standards that are being utilized and evaluated. Therefore the assessment of quality care indicators is critical to the VA to document whether high quality care is being provided to eligible veterans.

7. Explain any special circumstances that would cause an information collection to be conducted more often than quarterly or require respondents to prepare written responses to a collection of information in fewer than 30 days after receipt of it; submit more than an original and two copies of any document; retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years; in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study and require the use of a statistical data classification that has not been reviewed and approved by OMB.

There are no such special circumstances.

8. a. If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the sponsor's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the sponsor in responses to these comments. Specifically address comments received on cost and hour burden.

The notice of Proposed Information Collection Activity was published in the Federal Register on November 28, 2008 (Vol. 73, Number 230, Page 72399 through 72421). **VA received inquiries from eight commenters in response to this notice:**

We received a number of comments from eight commenters (one commenter provided two submissions). One commenter merely agreed with the proposed changes. The other comments are discussed below. Based on the rationale set forth in the proposed rule and this document, we have adopted the provisions of the proposed rule as a final rule with changes discussed below.

Nurse Practitioners

Proposed Sec. 51.2 defined the term "nurse practitioner" as "a licensed professional nurse who is currently licensed to practice in the State; who meets the State's requirements governing the qualifications of nurse practitioners; and who is currently certified as an adult, family, or gerontological nurse practitioner by a nationally recognized body that provides such certification for nurse practitioners, such as the American Nurses Credentialing Center or the American Academy of Nurse Practitioners."

Three commenters argued directly or implicitly that certification is not essential for the provision of high quality care and that licensure is a sufficient measure of competence. One of the commenters argued

that national certification would create an undue burden for nurse practitioners ("enroll in an exam course, pay for course work, travel, lodging and registration fees, and sit for the exam") and indicated that some may fail the exam or fail to meet renewal requirements. The commenter further asserted that nurse practitioners who are currently employed should be subject to a grandfather clause that allows them to work as nurse practitioners without national certification. We made no changes based on these comments. The proposed rule did not create a new certification requirement but merely broadened the list of certifying organizations to any nationally recognized certifying body because the previously listed organization does not provide such certification.

Recognition and Certification

Proposed Sec. 51.30(a)(1) provided that VA would not conduct the recognition survey until the new facility has at least 21 residents or the number of residents consists of at least 50 percent of the new bed capacity of the facility.

One commenter seemed to read the provisions at proposed Sec. 51.30(a)(1) by associating the portion of the formula regarding 21 residents with new facilities and associating the portion of the formula regarding 50 percent of the new bed capacity to renovations.

This is not what was intended. Both portions of the formula were intended to apply to recognition surveys. Accordingly, we clarified the regulation to state that the recognition survey will be conducted only after the new facility either has at least 21 residents or has a number of residents that consist of at least 50 percent of the new bed capacity of the new facility. We also note that under Sec. 51.30(b), a separate recognition is required for changes involving an annex, branch, enlargement, expansion, or relocation.

Two commenters asserted that the portion of the formula concerning 21 residents is excessive. One commenter noted that CMS (Centers for Medicare & Medicaid Services) only requires 3 residents to determine whether a facility meets the CMS standards. Another commenter asserted that a facility should only be required to have ten residents for an initial test survey and that per diem could begin after the initial test survey with a more detailed survey to follow. New providers/ suppliers must be in operation and providing services to patients when surveyed. This means that at the time of survey, the institution must have opened its doors to admissions, be furnishing all services necessary to meet the applicable provider or supplier definition, and demonstrate the operational capability of all facets of its operations. To be considered "fully operational," initial applicants must be serving a sufficient number of patients so that compliance with all requirements can be determined. Centers for Medicare & Medicaid Services, State Operations Manual, Pub. No. 100-07, Ch. 2 sec. 2008A. The commenters ultimately asserted that the proposed provisions would place a financial burden on veterans who might be responsible for costs until VA begins paying per diem. We made no changes based on these comments. Based on our experience in conducting surveys and following the progress of new State homes in meeting VA standards, the criteria as proposed set forth the minimum requirements (21 residents or 50 percent of new bed capacity) for conducting a survey that could determine whether a facility meets VA standards.

Proposed Sec. 51.30(d), (e), and (f) sets forth the process by which a State may appeal a decision by a director of a VA medical center of jurisdiction that a State home facility or facility management did not meet the standards of subpart D. The appeal is made to the Under Secretary for Health. The proposed provisions were intended to allow appeals to the Under Secretary in response to directors' recommendations regardless of whether the recommendations were made prior to recognition or after recognition. One commenter indicated that there is no procedure to appeal the decision of the Under Secretary. A decision of the Under Secretary, however, may be appealed to the Board of Veterans'

Appeals. For further information on this appeal process, please refer to 38 U.S.C. 7104 and 7105 and 38 CFR part 20. We clarified Sec. 51.30(f) to state that the decisions of the Under Secretary are final decisions that may be appealed to the Board of Veterans' Appeals. The commenter further asserted that there is no requirement that the Under Secretary take into account the arguments and evidence presented in a State's appeal. We made no changes based on this comment. Section 51.30(f) states that the Under Secretary will review any relevant supporting information. This would include the arguments and evidence presented by the State.

Rate Based on Service Connection

The provisions of 38 U.S.C. 1745(a), which were established by section 211 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. 109-461), set forth a mechanism for paying a higher per diem rate for certain veterans with service-connected disabilities receiving nursing home care in State homes.

Under this authority, the per diem rate was increased for:

Any veteran in need of nursing home care for a service-connected disability, and

Any veteran who has a service-connected disability rated at 70 percent or more and is in need of nursing home care.

Under the cited statutory authority, the new per diem rate is the lesser of the following:

The applicable or prevailing rate payable in the geographic area in which the State home is located, as determined by the Secretary, for nursing home care furnished in a non-Department nursing home (i.e., a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care); or

A rate not to exceed the daily cost of care in the State home facility, as determined by the Secretary, following a report to the Secretary by the director of the State home.

Several commenters seemed to be confused about the connection between higher per diem for certain veterans with service-connected disabilities and the provision of drugs and medicines to veterans in State homes. As more fully explained below, under the Veterans Benefits, Health Care, and Information Technology Act of 2006, VA does not have authority to provide drugs and medicines to veterans who are receiving care for which the higher per diem is payable.

Proposed Sec. 51.41(a)(2) stated that the higher per diem rate for certain veterans with service-connected disabilities would apply to a veteran with a rating of total disability based on individual unemployability. One commenter questioned whether all veterans must have a rating of total disability based on individual unemployability as a condition for receiving the higher rate of per diem based on service connection. Another commenter questioned whether Sec. 51.41(a)(2) would be applicable to an individual who is unemployable because of disabilities that are not service connected. We made no changes based on these comments. Veterans who are otherwise eligible for the higher per diem do not also need a rating of total disability based on individual unemployability from VA for the State to receive the higher rate of per diem on their behalf. However, the law permits VA to pay a higher per diem for veterans only based on their service-connected disabilities. States thus would not receive the higher per diem for veterans who are unemployable based on disabilities that are not service connected unless these veterans also have service-connected disabilities that meet the requirements for payment of the higher per diem.

With respect to the higher per diem rate for certain veterans in State homes, one commenter questioned whether a State home would receive different amounts based on the rating, i.e., 70 percent of the maximum per diem for a veteran with a rating of 70 percent, 80 percent of the maximum per diem for a veteran with a rating of 80 percent, and so on. We made no changes based on this comment. Under the statutory provisions of 38 U.S.C. 1745 and Sec. 51.41, the State home would receive the same per diem amount for these veterans.

With respect to the calculation of the higher per diem, commenters objected to the methodology in the proposed rule. One commenter asserted that the higher per diem rate should be the actual cost of care as determined by the State home. The commenter also asserted that the amount should be not less than the Medicare amount, the Medicaid amount, or the amount VA pays for veterans in private nursing homes.

One commenter argued that, compared to the population used in the proposed methodology, these service-connected veterans would need more care because they are generally older and mostly male. The commenter also indicated that the population used for the calculations would be based in large part on Medicare factors and asserted that some nursing homes do not take Medicare payments. The commenter further asserted that VA should use data from State homes. We made no changes based on these comments. The statutory provisions at 38 U.S.C. 1745 require that the new higher per diem rate be the lesser of the following:

> The applicable or prevailing rate payable in the geographic area in which the State home is located, as determined by the Secretary, for nursing home care furnished in a non-Department nursing home (i.e., a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care); or
>
> A rate not to exceed the daily cost of care in the State home facility, as determined by the Secretary, following a report to the Secretary by the director of the State home.

The law thus requires VA to use the actual cost of care in State homes based on a report from the home in determining the higher per diem, and the home will receive its actual cost if it is less than the applicable or prevailing rate. However, as stated in the preamble to the proposed rule: “VA is considering a modification to the proposed payment structure to be introduced after two or three years of experience with the [Resource Utilization Group-III (RUG III)] approach. In the modification, VA would use the actual case-mix of the individual state veteran nursing home to determine the reimbursement rate, rather than assuming that every nursing home has an equal number of veterans in each of the 53 RUG III levels. This modification will allow for more accurate payments, reimbursing nursing homes at a higher rate for treating veterans with more intensive needs.” One commenter asserted that we should use the earlier time frame of two years to take action to modify the payment structure. We made no changes based on this comment. We will work as fast as possible to take any actions necessary to improve the payment methodology.

One commenter asserted that there is no indication in the proposed rule as to how frequently adjustments would be made to payments under Sec. 51.41(b)(1) and further asserted that the regulations should include the process for adjustment. One commenter questioned whether VA would recalculate amounts each month for the higher per diem rate. In response, we note that the preamble to the proposed rule made clear that the adjustments would be made annually (see 73 FR 72401-72402). As stated in the preamble, the formula for establishing the rate includes CMS information that is published in the Federal Register every summer and is effective beginning October 1 for the entire fiscal year. We have added information in the note to Sec. 51.41(b)(1), explaining that adjustments will be made annually.

One commenter argued that the conclusion that the physician portion should be based on one hour per month is too little. Another commenter asked how the formula would include costs for physician extenders. Another commenter questioned whether a facility would receive a higher payment "if it is determined that each patient receives (and needs) substantially more than one hour of combined physician contact each month." Another commenter asserted that Texas does not use salaried physicians at their State homes and questioned whether Texas State homes would receive higher amounts to offset this practice. As an alternative, the commenter asserted that State homes should be allowed to continue to use Medicare Part B for the physician portion. We made no changes based on these comments. Based on our experience, we believe that one hour is the appropriate amount of time for the calculations for all of the primary care that would be provided by physicians or physician extenders as authorized under the regulations. The rate is based on averages, and it would not be administratively feasible to make a separate formula for each facility.

One commenter further asserted that State homes should not be required to pay for outside specialist costs. We made no changes based on this comment. Outside specialty care is not considered a part of nursing home care.

One commenter asked for VA to provide sample calculations to show how the formula works for VA's computation of the higher per diem. We made no changes based on this comment. The commenter was sent a sample calculation. We would be happy to provide sample per diem calculations to others upon request (see FOR FURTHER INFORMATION CONTACT above for contact information).

One commenter asserted that the higher per diem rate should be made applicable to VA programs outside of the State home program. We made no changes based on this comment because it is not within the scope of this rulemaking proceeding. This rule implements only the statutory provisions at 38 U.S.C. 1741-1743 and 1745 regarding nursing home care provided in State homes.

Drugs and Medicines

The provisions of 38 U.S.C. 1745(b) require VA to furnish recognized State homes with such drugs and medicines as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for certain veterans with service-connected disabilities.

One commenter questioned whether veterans for whom the higher per diem rate is payable would also receive drugs and medicines under section 1745(b). Two commenters argued that the payment of the higher per diem for veterans should not bar the receipt of drugs and medicines under 38 U.S.C. 1712(d) and corresponding VA regulations. One of the commenters questioned whether all veterans with a service-connected disability would receive drugs and medicines under proposed Sec. 51.41. We made no changes based on these comments. Section 1745(b) states that drugs and medicines provided under that statutory provision cannot be provided to veterans who are being provided nursing home care for which the higher per diem is payable. In addition, section 1745(a)(3) provides that payment by VA of the higher per diem constitutes payment in full to the State home for the veteran's nursing home care. We interpret this provision to mean that the higher per diem includes the cost of drugs and medicines, which provides the basis for the provision in Sec. 51.41 that, as a condition of receiving payments, the State home must agree not to accept drugs and medicines from VA on behalf of veterans provided under 38 U.S.C. 1712(d) and corresponding VA regulations. Also, section 1745(b) does not authorize VA to provide drugs to all veterans with a service-connected disability.

One commenter questioned, for purposes of proposed Sec. 51.42, who would determine if drugs and medicines are needed and how fast these determinations would be made. We made no changes based on

these comments. As indicated in Sec. 51.42, the physician prescribing the drug or medicine would make this determination. These determinations would be made in the normal course of business.

One commenter questioned whether a facility would have a choice in how the medications sent to the facility would be packaged, e.g., punch cards, unit doses, stock. We made no changes based on this comment. VA will work with State homes and when practical meet the requests of State homes for packaging the drugs and medications.

One commenter questioned how veterans would receive drugs and medicines that may be needed before they could be supplied by VA. Two commenters questioned how the State home would receive reimbursement for supplying such drugs and medications. We made no changes based on these comments. The statute at 38 U.S.C. 1745(b) does not authorize VA to reimburse States for the cost of drugs and medicines. However, as we have done in the existing VA program under which VA provides drugs and medicines to State homes on behalf of certain service-connected veterans, VA will work with State homes to establish working relationships that will allow for the most efficient methods of supplying drugs and medicines.

Retroactive Payments

Section 211(a)(5) of Public Law 109-461 required the higher per diem rate based on service connection to take effect on March 21, 2007 (90 days after enactment of the law). This authority also required that the provision of drugs and medicines for specified veterans take effect on the same date. Accordingly, the preamble to the proposed rule indicated that VA would make retroactive payments constituting the difference between the basic per diem actually paid and the higher per diem required for care provided to specified veterans on and after March 21, 2007. The preamble also indicated that VA would make retroactive payments constituting the amount State homes paid for drugs and medicines for specified veterans on and after March 21, 2007 (not including any administrative costs) (73 FR 72401).

The preamble to the proposed rule also asserted that VA would not make retroactive payments if the State home received any payment for such care or for such medicines and drugs from any source unless the amount received was returned to the payor (73 FR 72401). One commenter indicated that States should not be required to make refunds prior to receipt of VA payments because some States may not have sufficient funds to advance the payor. One commenter asserted that VA should establish a process for returning payments received under the Medicare and Medicaid programs. The commenter also asserted that VA should establish a process for reimbursing physicians who are not State employees and who obtained payments under Medicare Part B. One commenter asserted that a State should make repayments to the estate of a deceased veteran prior to receiving retroactive payments from VA that cover payments previously made by the veteran. We made no changes based on these comments. Regardless of whether the return of payment is made prior to VA's payment or immediately after VA's payment, the responsibility for the return of a payment rests with the State home that received the payment.

One commenter questioned whether VA will make retroactive payments from March 2007. As stated in the preamble to the proposed rule (73 FR 72401), VA will make retroactive payments for care provided on and after March 21, 2007, and for drugs and medicines provided on and after March 21, 2007.

Proposed Sec. 51.43(d) provided that per diem payments would be made retroactively for care that was provided on and after the date of the completion of VA's survey of the facility that provided the basis for determining that the facility met VA's standards. One commenter asserted that VA should pay per diem payments retroactively back to the date the State home opened for operation. We made no changes based on this comment. The statutory provisions at 38 U.S.C. 1741(d) provide for payment of per diem to

commence on the date of the completion of the inspection that recognized the State home as meeting VA's standards, as determined by the Secretary.

One commenter essentially questioned when new VA Form 10-0460 (captioned "Request for Prescription Drugs from an Eligible Veteran in a State Home") would be used by State homes. We made no changes based on this comment. The form should be used from the effective date of this document.

Time Limits

One commenter asserted that a State home should be given 30 days to apply for retroactive payments and monthly per diem and VA should be given 30 days to act on applications and begin making payments. We made no changes based on this comment. State homes are allowed to submit immediately for VA retroactive payments and are allowed to submit requests for monthly payments as soon as they are due. The regulation imposes no deadline on when States must seek retroactive payments. VA will respond promptly to States' requests but will not establish the deadline suggested by the commenter because it is difficult to predict the availability of resources at any given time.

Compensation

One commenter asserted that those veterans receiving VA compensation should not be required to use any of such funds for the cost of their State home care. We made no changes based on this comment. We know of no basis for treating VA compensation differently from other income or other funds of a resident except that the State home is prohibited from charging a veteran for nursing home care when VA pays the higher per diem rate based on service connection because VA's payment constitutes payment in full for the care provided (see 38 U.S.C. 1745(a)(3)).

Bed Holds

We proposed to make changes to the bed hold rule. Proposed Sec. 51.43© provided that per diem would be paid for a bed hold only if the veteran has established residency by being in the facility for 30 consecutive days (including overnight stays) and the facility has an occupancy rate of 90 percent or greater. In addition, we proposed that per diem for a bed hold would be paid "only for the first 10 consecutive days during which the veteran is admitted as a patient in a VA or other hospital (this could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care."

One commenter argued that residency should be established by admission and that a transfer to an acute care facility should not affect residency. The commenter further asserted that the proposed rule failed to provide a rationale for the residency requirement. One commenter asserted that the regulations should allow a bed hold for at least 15 days for a resident who is absent due to hospitalization unless the nursing home documents that it has objective information from the hospital confirming that the patient will not return to the nursing home within 15 days of the hospital admission. We made no changes based on these comments. As we indicated in the preamble to the proposed rule, VA believes that State homes should receive per diem for bed holds only if the State would likely fill the bed without such payments and only if the veteran has established residency at the State home (73 FR 72402). We believe that 30 days is a minimal amount of time for demonstrating that a veteran intends to be a resident at the State home and that the veteran was not temporarily placed in the State home.

With respect to hospital absences, one commenter questioned whether the regulations provide for VA to pay per diem "for only 10 consecutive overnight hospital absences or any number of overnight hospital absences but only up to ten consecutive days maximum period each time." We have clarified the regulations to state that VA will provide per diem "only for the first 10 consecutive days during which the

veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year)."

One commenter asserted that the 90 percent occupancy requirement should not apply to a new facility for the first two years of operation. The commenter asserted that this would afford the time to safely fill the building to the 90 percent occupancy rate. We made no changes based on this comment. The request is inconsistent with the purpose of a bed hold. As stated in the preamble to the proposed rule, payments for bed holds are intended to assure that nursing home residents who are hospitalized or who are granted leave for other purposes are assured a nursing home bed upon return to the nursing home (73 FR 72402). It is unlikely that facilities with an occupancy of less than 90 percent would fill the bed of an absent resident.

One commenter questioned how to determine when a facility has an occupancy rate of 90 percent or greater. We made no changes based on this comment. The occupancy rate would be determined by dividing the number of residents by the number of beds identified in the recognition process. If a facility is recognized as a 100 bed facility and has 90 residents, the occupancy rate is 90 percent.

One commenter asserted that their facility was constructed with a 400-bed capacity but now, because of a nurse shortage, operates at a maximum of 300 beds. The commenter asked whether the 90 percent requirement would apply to the lower amount. We made no changes based on this comment. The lower amount would apply only if the amount were based on a formal re-recognition action.

Resident Rights

Proposed Sec. 51.70©(5) provided that "[u]pon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows." One commenter asserted that the regulations should provide a waiver from the 90 day requirement in those cases when "funds are inadequate, there are multiple creditors and relatives and the matter is tied in probate or no relative or creditor is located or willing to open an estate." We made no changes based on this comment. The regulations only require that the time limit be met when the funds can be conveyed "to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows." VA sees no reason why funds should be retained for longer periods under these circumstances.

Quality of Life

Proposed Sec. 51.100(h)(2) clarified the regulations to specify that a nursing home with 100 or more beds would be required to employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). We also proposed to clarify the regulations to specify that a State home must provide qualified social worker services in proportion to the total number of beds in the home, specifically one or more social worker FTE per 100 beds. For example, under the proposal a nursing home with 50 beds would be required to employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 150 beds would be required to employ qualified social workers who work for a total period equaling at least one and one-half FTE. One commenter asserted that this requirement is too onerous and that others could perform the social work under the supervision of a social worker. The commenter further asserted that a grandfather clause, a waiver, or a phase-in time should be allowed for those not meeting the requirement. The commenter also asserted that, instead of a 1:100 ratio, VA should establish the ratio of 1:120.

We believe that a resident must have access to a quality social work program to help ensure the well being of the resident. We believe that we could increase the ratio to 1:120, which is the CMS standard and still allow for sufficient availability of social workers. Accordingly, the final rule reflects this change. However, we made no further changes because we believe that only qualified social workers would have the skills necessary to provide this specialized help needed by residents.

Resident Assessment

Section 51.110 requires facility management to "conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." Section 51.110(b)(3) also requires quarterly reassessments.

Proposed Sec. 51.110(b)(1)(i) required officials conducting such assessments, among other things, to use the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set (RAI/MDS), Version 2.0. Two commenters asserted that the version will be updated and that we should use a generic reference so that we could require compliance with the changed versions as they are adopted. We made no changes based on these comments. We prefer our incremental approach because it allows us to review each new version of the standard prior to making it applicable.

Two commenters asserted that VA should clarify the purposes for such CMS RAI/MDS submissions. One of the commenters further questioned whether VA would calculate RUG scores from this information and questioned how differences between VA and facilities would be resolved. We made no changes based on these comments. The purpose for obtaining the information is not to challenge the data reviewed. VA uses the quality indicators to prepare for surveys.

Also, we proposed to require each State home to submit each assessment to VA at a VA email address. Two commenters asserted that facilities should be able to submit the data by electronic means other than email. We agree that the information should be submitted electronically in a form other than email. Accordingly, the final rule requires the submission to be made electronically to the IP address provided by VA.

Physical Environment

Proposed Sec. 51.200 required State home facilities to meet certain provisions of the National Fire Protection Association's NFPA 101, Life Safety Code and the NFPA 99, Standard for Health Care Facilities. These documents are incorporated by reference in accordance with the provisions of 5 U.S.C. 552(a) and 1 CFR Part 51. We proposed to change the regulations to update these documents to refer to the current editions of the NFPA code and standard. One commenter asserted that the updates should apply only to new construction and renovation. The commenter further asserted that existing State homes "should be grandfathered and assessed under the standards that were in place when the Homes were constructed and initially surveyed." These documents represent national consensus standards that are generally recognized as minimum standards for life and safety. Ultimately, we believe that State homes must work to protect residents by meeting the minimum consensus standards contained in these documents.

The standards for existing facilities take into account that some changes may take a considerable amount of time to make, such as installation of sprinkler systems for existing nursing homes. The Centers for Medicare & Medicaid Services (CMS) has determined that August 13, 2013, provides a reasonable amount of time to install sprinkler systems in existing nursing homes, as required by paragraph 19.3.5.1 in the 2006 edition of NFPA 101, which specifically states "Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section

9.7, unless otherwise permitted by 19.3.5.4." We agree, and therefore based on the above comment we have included such a requirement in the final rule. We note that paragraph 13-3.5.1 in the 1997 edition of NFPA 101 requires sprinkler protection for buildings of certain construction types. The requirement for sprinkler protection due to construction type is also found in paragraph 19.1.6 in the 2006 edition of NFPA 101. The changes in Sec. 51.200 are not intended to postpone enforcement of the existing requirement for sprinkler protection in nursing homes due to the construction type of the building.

The proposed rule indicated that we would incorporate by reference the 2006 edition of the standard. This was in error since the latest edition of the standard is the 2005 edition. Therefore, we are incorporating by reference the 2005 edition.

b. Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, clarity of instructions and recordkeeping, disclosure or reporting format, and on the data elements to be recorded, disclosed or reported. Explain any circumstances which preclude consultation every three years with representatives of those from whom information is to be obtained.

Outside consultation is conducted with the public through the 60- and 30-day Federal Register notices.

9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.

No payment or gift is provided to respondents.

10. Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statue, regulation, or agency policy.

VA Form 10-10SH collects individually identifiable information covered by the Privacy Act. Assurances of confidentiality for this form are contained in 38 U.S.C. 5701 and 7332. Respondents are informed that the information collected will become part of the Consolidated Health Record that complies with the Privacy Act of 1974. These forms are part of the system of records identified as 24VA136 "Patient Medical Record – VA" as set forth in the 2003 Compilation of Privacy Act Issuances via online GPO access at http://www.gpoaccess.gov/privacyact/2003.html. The other forms in this group contain information that is not protected by the Privacy Act. The forms are filed at VA Central Office for initial recognitions of the new State Homes and fiscal forms are maintained at the VA Medical Center (VAMC) of jurisdiction for the State Home Per Diem Program.

11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private; include specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

VA Form 10-10SH contains questions that may be considered sensitive. This information is required under regulation as a minimum to determine the level of care. Disclosure is voluntary; however, the information is required to determine the eligibility for the medical benefit for which applied. The law requires that Per Diem Payments to states be made only for services provided to veterans in need of such care. The information is collected and maintained by the VA Medical Center (VAMC) of jurisdiction in

accordance with the policies of patient records management. All medical records of patients are protected under the Privacy Act of 1974, VA and HIPPA regulations, and medical center policies.

12. Estimate of the hour burden of the collection of information:

a. Using 2006 data, we estimate 15,550 total burden hours annually.

(1) VA Form 10-3567, State Home Inspection - Staffing Profile = **90 hours annually**.

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	1	180	30	90 hours

(2) VA Form 10-5588, State Home Report and Statement of Federal Aid Claimed = **1,080 hours annually**.

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	Monthly	2,160	30	1,080

(3) VA Form 10-1OSH, State Home Program Application for Veteran Care - Medical Certificate = **10,566 hours annuall**y.

Program	Respondents	Frequency	Responses	Min. Each	Burden Hours
State Nursing Home	9,048	1	9,048	30	4,524
State Domiciliary	2,355	1	2,355	30	1,178
State Hospital	9,726	1	9,726	30	4,863
Adult Day Health Care (ADHC)	3	1	3	30	2
Totals:	21,132	1	21,132		10,566

(4) VA Form 10-0143, Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements For Grantees Other Than Individuals = **15 hours annually**

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	1	180	5	15

(5) VA Form 10-0143a, Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973 = **15 hours annually**

Respondents	Frequency	Responses s	Min. Each	Burden Hours
180	1	180	5	15

(6) VA Form 10-0144, Certification Regarding Lobbying = **15 hours annually**

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	1	180	5	15

(7) VA Form 10-0144a, Statement of Assurance of Compliance with Equal Opportunity

Laws = **15 hours annually**.

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	1	180	5	15

(8) VA Form 10-0460, Request for Prescription Drugs from an Eligible Veteran in a State Home = **15 hours annually**.

Respondents	Frequency	Responses	Min. Each	Burden Hours
180	1	180	5	15

(9) Section 51.20, Application for Recognition (Letter to Under Secretary for Health) = **2 hours annually**.

Updated Program	Respondents	Frequency	Responses	Min. Each	Burden Hours
State Nursing Home	10	1	10	6	1
State Domiciliary	5	1	5	6	0.5
State Hospital	0				
ADHC	5	1	5	6	0.5
Totals:	20		20		2

(10) Section 51.30, Recognition & Certification and Section 52.30, Recognition & Certification = **120 hours annually**.

Type	Type of Facility	Respondents	Frequency	Responses	Hours Each	Burden Hours
Major Deficiency	State Nursing Homes	10	1	10	3	30
	State Domiciliary	5	1	5	3	15
	State Hospitals	0	1	0	3	0
	ADHC	0	1	0	3	0
Minor Deficiency	State Nursing Homes	50	1	50	1	50
	State Domiciliary	25	1	25	1	25
	State Hospitals	0	1	0	1	0
	ADHC	0	1	0	1	0
Totals		90		90		120

(11) Section 51.70, Residents Rights, Section 51.90, Resident Behavior & Family Practices, Section 52.70, Participant Rights & Section 52.71, Participant & Family Caregivers Responsibilities = **1,813 hours annually**.

Program	Respondents	Frequency	Responses	Min. Each	Burden Hours
State Nursing Home	17,736	1	17,736	5	1,478
State Domiciliary	3,845	1	3,845	5	320
State Hospital	168	1	168	5	14

ADHC	2	1	2	5	0
Totals	21,751		21,751		1,813

(12) Section 51.80, Admission, Transfer and Discharge Rights and Section 52 80, Enrollment, Transfer and Discharge Rights --171 respondents totaling **1 hour annually** *(Enrollment, admission and discharge records are customary in nursing homes, domiciliary, hospitals, and adult day health care facilities.)*

(13) Section 51.100, Quality of Life and Section 52.100, Quality of Life = **360 hours annually**.

Program	Respondents	Frequency	Responses	Min. Each	Burden Hours
State Nursing Home	118	4	472	30	236
State Domiciliary	55	4	220	30	110
State Hospital	5	4	20	30	10
ADHC	2	4	8	30	4
Totals	180		720		360

(14) Section 51.110, Resident Assessment and Section 52.110, Participant Assessment (Clinical record keeping) --171 respondents totaling **1 hour annually** *(Clinical recordkeeping is a customary practice.)*

(15) Section 51.120, Quality of Care and Section 52.120, Quality of Care **= 0 hours annually** *(This is not counted in the burden estimate, as we project only three respondents.)*

(16) Section 51.180, Pharmacy Services and Section 52.180, Administration of drugs –180 respondents totaling **1 hour annually** *(Recordkeeping for control drugs and report irregularities are a customary practice.)*

(17) Section 51.190, Infection Control and Section 52.190, Infection Control --180 respondents totaling **1 hour annually** *(Incident reports are a customary practice in nursing homes and adult day health care facilities.)*

(18) Section 51.210, Administration and Section 52.210, Administration = **1,440 hours annually** *(Documentation of items listed below are customary practices in State Nursing Home Programs. Recognition items are a "one time" submission; all others are surveyed and reported annually.*

(a) Section 51.210(b)(1) — Disclosure of State Agency and Individual Responsible for Oversight of Facility and Section 52.2 10 (b)(1) — Disclosure of State Agency and Individual Responsible for Oversight of Facility
(b) State Law (recognition)
(c) Site Plan (recognition)
(d) Legal Title (recognition)

(e) Organization Chart and Operational Plan (recognition)
(f) Number of Staff
(g) Number of Patients
(h) Section 51,210(c)(7) — State Fire Marshall Report
(i) Credentialing and Privileging
(j) Nurse Aide Registry Verification
(k) Nurse Aide/Program Assistant Inservice
(l) CLIA # and Annual Report
(m) Quality Assessment and Assurance
(n) Disaster and Emergency Preparedness

Program	Respondents	Frequency	Responses	Hours Each	Burden Hours
State Nursing Home	118	1	118	8	944
State Domiciliary	55	1	55	8	440
State Hospital	5	1	5	8	40
Adult Day Health Care (ADHC)	2	1	2	8	16
Totals	180		180		1,440

b. If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13 of OMB 83-I.

See attachment to OMB Form 83-I.

c. Provide estimates of annual cost to respondents for the hour burdens for collections of information. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.

Estimated cost to respondents: $684,200 (15,550 burden hours x $44 per hour). We do not require any additional recordkeeping.

13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 and 14).

a. There is no capital, start-up, operation or maintenance costs.

b. Cost estimates are not expected to vary widely. The only cost is that for the time of the respondent.

c. There are no anticipated capital start-up cost components or requests to provide information.

14. Provide estimates of annual cost to the Federal Government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operation expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.

The estimated total cost to the Federal Government is $1,054,682.

a. Review by VA medical center officials -$705,984
[11,031 hours x $64.00 (average GS-14 step 10 hourly salary)]

b. Clerical support - $207,262
[777 hours x $38.00 (average GS-1l step 10 hourly salary) = $29,526]
[6,836 hours x $26.00 (average GS-7 step 10 hourly salary) = $177,736]

c. VA Headquarters oversight review - $137,936
[1,864 hours x $74.00 (clinical grades = to average GS-15 step 10 hourly salary) = $137,936]

d. Printing costs - $4,000

15. Explain the reason for any changes reported in Items 13 or 14 above.

The adjustment of 408 burden hours is due to the increase of 11 Nursing Homes, six Domiciliaries and 2 Adult Day Health Care Centers utilizing this program.

16. For collections of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.

There are no plans to publish the results of this information collection.

17. If seeking approval to omit the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

VA seeks to minimize the cost to itself of collecting, processing and using the information by not displaying the expiration date. We seek an exemption that waives the displaying of the expiration date on this VA Form. If we are required to display an expiration date, it would result in unnecessary waste of existing stock of the forms stocked at the State Homes. If we are required to display an expiration date, it would result in unnecessary waste of existing stock of the forms. Inclusion of the expiration date would place an unnecessary burden on the respondent (since they would find it necessary to obtain a newer version, while VA would have accepted the old one).

18. Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB 83-I.

There are no exceptions.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

No statistical methods are used in this data collection.