Kentucky Veterans' Centers

Research Report No. 502

Legislative Oversight And Investigations Committee

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Legislative Oversight And Investigations Committee

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Abstract

This report presents an evaluation of Kentucky veterans' centers, focusing on facility operations, capacity, admissions practices, staffing conditions, financial structure, and alignment with federal long-term care standards. The primary objective of the report was to evaluate occupancy and capacity and determine if they are problematic and whether they are impacting revenue or access to care. The study draws on facility interviews and site visits, interviews with the Kentucky Department of Veterans' Affairs, analysis of census and admissions data, analysis of state and federal funding, and review of state and federal statutory and regulatory requirements governing veterans' long-term care. Findings show that although certified occupancy appears low, analysis of functionally available beds reveals that functional occupancy is higher and exceeds the national average. Analysis also reveals that increases in occupancy or capacity are unlikely to result in increases in revenue. While some facilities have faced periods of staffing pressure, recent improvements due to funding adjustments suggest that staffing challenges may be stabilizing. The study also finds that while all Kentucky veterans' centers provide consistently strong quality of care, they also face challenges from aging infrastructure, extended capital projects, transitioning to single-occupancy rooms for residents, caring for residents with significant behavioral health care needs, and a population of residents with increasingly complex clinical needs. The study highlights several opportunities to improve operations: modernizing outdated facilities, strengthening data collection and admissions documentation, formalizing waiting list and communication procedures, and planning for long-term transitions to single-occupancy rooms consistent with federal best practices. The report presents 18 recommendations to improve operations, data systems, communication, and facility modernization, and 4 matters for legislative consideration focusing on statutory updates, improved reporting requirements, and oversight of ongoing capital projects.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. We are grateful to the staff of the Kentucky Department of Veterans' Affairs and the staff of the Office of Kentucky Veterans' Centers for their invaluable support. Their assistance was instrumental in helping us understand operations, providing data, responding to information requests, giving tours of each state veteran home, as well as sharing firsthand knowledge of each facility.

Committee staff wish to recognize the administrators and staff of all Kentucky veterans' centers: the Carl M. Brashear Radcliff Veterans Center, the Paul E. Patton Eastern Kentucky Veterans Center, the Joseph "Eddie" Ballard Western Kentucky Veterans Center, the Thomson-Hood Veterans Center, and the Robert E. Spiller Bowling Green Veterans Center.

We thank the administrators and caregivers at these facilities not only for their contributions to this project, but also for the dedication, compassion, and professionalism with which they care for Kentucky's veterans. Their commitment to prioritizing veterans' quality of life and ensuring that residents receive the highest standard of care is evident. We also extend our appreciation to the residents who spoke with us during our site-visits and shared their experiences.

We also acknowledge the Ohio Department of Veterans Services, the Tennessee Department of Veterans Services, and the Michigan Department of Military and Veterans Affairs. Their expertise, perspectives on challenges and best practices, and willingness to meet with us provided valuable comparative insight that strengthened our analysis. The National Association of State Veterans Homes also served as a helpful resource.

We appreciate the support of the US Department of Veterans Affairs for providing requested information.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
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Summary

On February 3, 2025, the Legislative Oversight and Investigations Committee directed staff to examine the operation and management of the Kentucky state veterans' centers, with a primary focus on evaluating occupancy and capacity and determining whether these factors are limiting revenue or veteran access to care. The study finds that, although certified occupancy rates seem low, analysis of functional operating capacity shows that facilities are operating at higher occupancy levels than reported. Moreover, neither revenue nor access to care appear to be constrained by current occupancy or capacity levels.[1] Any potential revenue gains from increasing census would be modest relative to the cost required to achieve them; and admissions decisions, specifically denials, deferrals, and placements to waiting lists, appear to be driven primarily by clinical factors such as physical and behavioral health acuity, or voluntary decisions by applicants to delay entry, rather than by facility capacity.

Two important caveats qualify these findings regarding access to care. Kentucky's declining overall veteran population suggests that current capacity is sufficient to meet present demand. However, rising levels of acuity and behavioral health needs among Kentucky veterans indicates that the number of veterans requiring long-term care may be increasing, potentially creating future capacity pressures that current facilities may not be equipped to manage. In addition, inconsistent and subjective documentation of admissions and waitlist activity by Kentucky veterans' centers prevents definitive conclusions about underlying demand for long-term care or the system's ability to fully meet the needs of all applicants.

Although staffing had been a significant challenge since the COVID-19 pandemic, it appears to have stabilized following funding and pay adjustments recently approved by the legislature. Staffing levels across Kentucky's four veterans' centers appear adequate for current functional capacity, with facilities maintaining a high share of filled positions relative to operable beds. Moreover, the report found no evidence that current occupancy levels, capacity constraints, or staffing conditions have diminished the quality of care provided. Kentucky veterans' centers consistently receive strong quality ratings from the Centers for Medicare and Medicaid Services and maintain performance scores that exceed national averages.

Taken together, these findings show that occupancy, capacity, and staffing conditions are not currently limiting revenue or access to care and that quality of care is high, Kentucky veterans' centers face operational challenges related to caring for veteran behavioral health needs, increasing physical acuity among residents, aging infrastructure, ongoing capital projects, the transition to single-occupancy rooms, and poor data collection and standardization of procedures. Opportunities for systemwide improvement include greater standardization of admissions and waitlist procedures, clearer communication with applicants and stakeholders, creation of a formal appeals process, annual reporting, decertification of unused beds, continued facility modernization, expansion of behavioral health capacity, continued deployment of staffing incentives, and a continued transition toward single-occupancy rooms.

[1] Veterans' centers are not profit-generating facilities but they receive revenue through medical reimbursements, state general funds, and insurance payments.

Major Objectives

This study had 10 major objectives.

- Review the state statutory and regulatory framework governing Kentucky veterans' centers and assess alignment with the Kentucky Department of Veterans' Affairs (KDVA) administrative regulations, state budget language, and state statute.
- Review the federal statutory and regulatory framework applicable to state veterans' homes and assess alignment with the federal Department of Veterans Affairs (VA) and the Centers for Medicare and Medicaid Services (CMS) standards.
- Examine the state and federal funding mechanisms for the Kentucky state veterans' centers and report on the centers' revenue and expenditures.
- Analyze census and capacity at Kentucky veterans' centers to evaluate occupancy rates and understand how physical design, functional capacity, staffing, and ongoing capital projects influence the system's ability to operate efficiently and provide care.
- Determine whether current occupancy rates and facility capacity are denying Kentucky veterans access to care or limiting potential state revenue.
- Evaluate staffing levels and staffing policies at Kentucky veterans' centers to assess workforce shortages potential impacts on capacity.
- Examine admissions and denial processes to determine whether they are standardized, transparent, and consistently applied across veterans' centers.
- Assess the current status of admissions decisions and waiting lists to determine current demand for veteran long-term care and evaluate if this demand is unmet due to capacity constraints.
- Evaluate facility operational and modernization needs, including the transition from double- to single-occupancy rooms, ongoing capital projects, and facility renovations.
- Assess major challenges facing Kentucky veterans' centers and recommend solutions based upon best practices.

Major Conclusions

This study has 18 major conclusions:

- Kentucky veterans' centers are currently operating at 56 percent of certified capacity, which is below the national average. However, when adjusting for functionally available beds by removing unused beds pending decertification and those temporarily unavailable due to construction projects, the adjusted occupancy rises to 85 percent, exceeding the national average.
- Current capacity and occupancy levels do not appear to be primary drivers of admissions denials, deferrals, or waitlist placements. Instead, the main factors are applicants whose behavioral or physical health needs exceed what veterans' centers can safely accommodate, along with applicants choosing to forgo admission.
- Application denials due to behavioral health appear to be the primary driver of applicant or constituent frustration with admissions and waiting list processes.
- KDVA should improve, formalize, and standardize their data collection, management, and analysis capabilities with respect to admissions decisions and waitlist management.

- KDVA should formally define waiting lists and distinguish active lists, where applicants are waiting due to capacity constraints or acuity or behavioral health evaluations, from interest lists, where applicants have placed their names on lists for future consideration.
- Capital projects, staffing limitations, and inaccurate reporting of true capacity are the primary factors leading to low occupancy rates at Kentucky veterans' centers.
- Certified but unused beds are misrepresenting occupancy data, which may cause negative outcomes for Kentucky veterans' centers by keeping occupancy rates lower. Lower occupancy rates make bed holds impossible, building new facilities more difficult, and miscommunication with stakeholders more likely.
- KDVA should report both certified and functional capacity and occupancy rate in order to properly communicate these to applicants, the General Assembly, and other stakeholders.
- KDVA should decertify beds at Thomson-Hood Veterans Center (THVC) and Western Kentucky Veterans Center (WKVC) that are no longer in use due to transition from double- to single-occupancy rooms.
- KDVA should develop a plan for transitioning all veterans long-term care facilities to single-occupancy rooms in order to improve resident quality of life, consistency of resident experience across centers, health outcomes, and infection control.
- Quality of care for veterans in Kentucky veterans' centers is higher than the national average.
- The capital project to replace the HVAC system at Radcliff Veterans Center (RVC) has caused capacity constraints for the Kentucky veterans' center system. Given concerns surrounding the project, specifically the replacement outside of warranty and soon after installation, the project should be reviewed by the Auditor of Public Accounts or the Office of the Attorney General.
- The Thomson-Hood Veterans Center would benefit from continued modernization efforts.
- Some Kentucky veterans' centers report difficulty filling staffing positions or personnel limits that are too low. The Kentucky Personnel Cabinet and KDVA should work to evaluate the need to maintain or expand staffing incentives and personnel caps for some Kentucky veterans' centers.
- The Kentucky veterans' center system could benefit from centralization of some operations and standardization of some policies and procedures.
- Current statutory and regulatory language governing state veterans' centers uses inconsistent terminology and could cause confusion. The language should be revised for consistency and alignment with federal standards. The study recommends revising "veterans' centers" to "veterans homes."
- Kentucky veterans' centers require general fund support for every resident. While the centers are reimbursed for medical expenditures, the reimbursements are insufficient to cover the cost of care. Increasing the number of residents housed at the centers would likely require additional financial support from the General Assembly.
- Inconsistent and subjective methods for documenting admissions outcomes and maintaining waitlists across Kentucky veterans' centers prevent definitive conclusions and accurate evaluations of underlying need. As a result, it limits the state's ability to determine with confidence whether the system is fully meeting veteran demand for long-term care.

Recommendations And Matters For Legislative Consideration

The following recommendations and matters for legislative consideration fall into four categories listed below along with their associated chapters. The recommendations are categorized for conceptual clarity and appear in a different order than in the body of the report. The report includes 18 recommendations and 4 matters for legislative consideration.

Regulatory And Statutory Language Alignment
- Discussed in Chapter 2
- Includes 1 recommendation
- Includes 1 matter for legislative consideration

Facility Modernization And Infrastructure
- Discussed in Chapters 2 and 3
- Includes 9 recommendations
- Includes 2 matter for legislative consideration

Reporting Practices, Data Quality, And Transparency
- Discussed in Chapters 3 and 4
- Includes 6 recommendations
- Includes 1 matter for legislative consideration

Behavioral Health Care
- Discussed in Chapter 4
- Includes 2 recommendations

Regulatory And Statutory Language Alignment

Kentucky's statutory and regulatory terminology for its long-term care facilities is internally inconsistent and differs from the terminology used by federal partners, most notably the United States Department of Veterans Affairs and the Centers for Medicare & Medicaid Services. This inconsistency complicates comparison with federal standards, hinders alignment with national reporting frameworks, and may create confusion for stakeholders who rely on uniform terminology across programs. To strengthen clarity, improve consistency, and better align Kentucky's system with federal long-term care language, the following recommendation and matter for legislative consideration propose updates to both KDVA's administrative regulations and state statute.

Recommendation 2.1

The Kentucky Department of Veterans' Affairs should revise their regulatory language to replace references to "veterans' centers" with "veterans homes" to improve consistency and align Kentucky's language with federal long-term care language from the US Department of Veterans Affairs and the Centers for Medicare and Medicaid Services.

Matter For Legislative Consideration 2.A

The General Assembly may wish to revise their statutory language, specifically KRS Chapter 40, to replace references to "veterans' centers" with "veterans homes" to improve consistency and align Kentucky's language with federal long-term care language from the US Department of Veterans Affairs and the Centers for Medicare and Medicaid Services.

Facility Modernization, Capacity, And Infrastructure

Thomson-Hood Veterans Center is the oldest Kentucky state veterans' centers, and its aging facilities present ongoing operational challenges. While the facility continues to provide strong quality of care, decades-old infrastructure and outdated layouts have made modernization increasingly important to ensure quality of care, efficiency, and an environment that aligns with contemporary long-term care standards and the quality of Kentucky's other veterans' centers.

Recommendation 2.2

The Kentucky Department of Veterans' Affairs should provide a report to the General Assembly on the current modernization needs associated with the Thomson-Hood Veterans Center. The report should include a review and update on the current capital projects underway and should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

As part of a broader effort of modernization, Thomson-Hood Veterans Center is transitioning toward a modern, single-occupancy room model to better support privacy, infection control, and resident quality of care. As census levels rise in the coming years, maintaining this model will be essential to preserving quality of care and ensuring the facility does not revert to outdated double-occupancy configurations.

Recommendation 2.3

The Kentucky Department of Veterans' Affairs should continue to prioritize the use of single-occupancy rooms at Thomson-Hood Veterans Center as resident census levels increase.

The Thomson-Hood Veterans Center has already informally transitioned many former double-occupancy rooms into single-resident spaces. To ensure that reported capacity accurately reflects current operations, KDVA should decertify the beds in these rooms that are no longer used for double occupancy. This will allow for more accurate capacity and occupancy rate reporting as well as bringing Kentucky's occupancy rates more in line with policy thresholds, such as the state's 80-percent requirement for authorizing new facilities and the VA's 90-percent threshold for bed-hold reimbursement.

Recommendation 2.4

The Kentucky Department of Veterans' Affairs should decertify beds at Thomson-Hood Veterans Center that have been informally transitioned from double- to single-occupancy. The department should report on the progress of decertification to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

As Kentucky veterans' centers move toward a modern single-occupancy room model, long-term planning will need to consider how this transition can be implemented consistently across the system. Although Eastern Kentucky Veterans Center (EKVC) currently operates exclusively with double-occupancy rooms, has strong staffing rates and quality of care metrics, is at full capacity, and would pose a difficult transition to single-occupancy, it should be included in future systemwide transition to single-occupancy planning.

Recommendation 2.5

The Kentucky Department of Veterans' Affairs should include the Eastern Kentucky Veterans Center in long-term systemwide planning and feasibility assessments related to transitioning to single-occupancy rooms.

Kentucky's long-term care landscape for veterans has changed considerably since the last statewide facility expansion feasibility study. Two new veterans' centers have opened in the areas previously identified as having the highest unmet need, and the earlier study did not account for the system's current transition toward single-occupancy rooms or other modernization efforts that affect overall capacity. As the commonwealth evaluates future capital investments, it is important to reassess whether unmet need persists and how projected demand may shift under a single-occupancy model. Conducting a new statewide location feasibility study prior to any construction or expansion decisions would provide the General Assembly with an updated, data-driven basis for determining whether additional facilities are warranted.

Recommendation 2.6

Prior to new construction or facility expansion decisions, the Kentucky Department of Veterans' Affairs should conduct a new statewide veterans' center location feasibility study to evaluate the need for future facility construction or expansion. The study should account for the opening of the two most recent veterans' centers, which addressed the two previous highest areas of need identified in the state; and account for the potential impact of transitioning all state veterans' centers to single-occupancy room configurations.

Western Kentucky Veterans Center has historically had staffing challenges which may have recently stabilized following the implementation of special entry rates and locality premiums. KDVA reports that the facility will likely still find staffing a challenge and that it may ultimately need to operate at a smaller, single-occupancy-aligned capacity to remain sustainable. Alternatively, WKVC staff report that, while the facility may be adequately staffed at its current

personnel cap, a higher cap is needed to increase staffing to fully meet demand. Given these competing considerations, and the effectiveness of locality premiums and special entry rates, a coordinated review by KDVA and the Personnel Cabinet is needed to determine whether continued or expanded staffing salary flexibilities are warranted.

Recommendation 2.7

The Kentucky Department of Veterans' Affairs should work with the Kentucky Personnel Cabinet to evaluate if increased locality premiums and special entry rates are warranted, and whether increased personnel limits are justified for positions at the Western Kentucky Veterans Center.

Similar to THVC, WKVC has informally converted a number of double-occupancy rooms to single-occupancy use in order to better reflect resident needs, staffing realities, and contemporary standards of care. However, the certified bed count has not been updated to reflect this change, creating a mismatch between reported and functional capacity. Decertifying these unused beds would align the facility's certified capacity with its actual operating model; improve the accuracy of reported occupancy and capacity data; and reduce confusion regarding available space.

Recommendation 2.8

The Kentucky Department of Veterans' Affairs should decertify beds at Western Kentucky Veterans Center that have been informally transitioned from double- to single-occupancy. The department should report on the progress of decertification to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

The Radcliff Veterans Center has experienced significant operational and financial challenges stemming from the procurement, installation, repair, warranty coverage, and replacement of its HVAC system. Given the scope of these issues and the prolonged impact on facility operations and resident capacity, the General Assembly may wish to refer this matter to the Office of the Auditor of Public Accounts and the Office of the Attorney General for independent review. Such a review could help determine whether procurement processes were followed, whether contractor performance and warranty obligations were met, and whether the state is entitled to any legal or financial recourse from the vendor.

Matter For Legislative Consideration 2.B

The General Assembly may wish to refer the matter of the procurement, installation, repair, warranty coverage, and replacement of the HVAC system installed at the Radcliff Veterans Center to the Office of the Auditor of Public Accounts and the Office of the Attorney General for review.

State and federal standards increasingly emphasize the importance of single-occupancy rooms in long-term care settings, both to enhance resident dignity and privacy and to reduce infection control risks. In light of these priorities, KDVA should evaluate the feasibility and implications of transitioning all Kentucky veterans' centers to single-occupancy rooms statewide and report its findings, along with the current status of each facility, to the General Assembly. This evaluation should include an assessment of maintaining single-occupancy configurations at the THVC and the WKVC, as well as the steps, costs, and operational impacts associated with transitioning the EKVC to single-occupancy rooms.

Recommendation 3.1

The Kentucky Department of Veterans' Affairs should evaluate transitioning all Kentucky veterans' centers to single-occupancy rooms statewide and report their findings and the status of current facilities to the General Assembly. In addition to evaluating and maintaining single-rooms occupancy at the Thomson-Hood Veterans Center and the Western Kentucky Veterans Center, the report should investigate transitioning Eastern Kentucky Veterans Center to single-occupancy rooms. The report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Kentucky's veterans' centers do not generate revenue and instead require additional state funding for each additional resident admitted to a facility due to the standards of care. From FY 2020 to FY 2024, the veterans' centers received an average annual general fund appropriation of $24 million. The centers receive funding from the VA and CMS for eligible veterans, but increasing the number of eligible veterans is unlikely to offset the need for general fund appropriations. Increasing occupancy may allow for additional financial support through bed-holds but the bed-hold revenue would likely be low relative to increased costs from additional residents.

Matter For Legislative Consideration 3.A

If it is the intent of the General Assembly to increase the number of veterans cared for at Kentucky veterans' centers, then the General Assembly may wish to plan for increased cost rather than increased revenue.

Special entry rates and locality premiums have been effective at improving staffing and retention at Kentucky veterans' centers. KDVA should work with the Personnel Cabinet to evaluate whether current staffing incentives for each Kentucky veterans' center region are sufficient or should be expanded.

Recommendation 3.3

The Kentucky Department of Veterans' Affairs should work with the Kentucky Personnel Cabinet to evaluate whether staffing incentives, in the form of special entry rates and locality premiums, are sufficient or should be expanded for each Kentucky veterans' center region.

Reporting Practices, Data Quality, And Transparency

Accurate assessments of facility utilization are essential for effective oversight and informed budgeting. Certified occupancy rates and facilities capacities, while useful, do not fully reflect the beds that Kentucky veterans' centers are able to staff and operate at any given time. Reporting functional occupancy rates and functional facility capacity, which consider how capacity has been affected by capital projects and single-occupancy room transitions, provides a more realistic picture of how facilities are performing and where operational constraints may exist. To improve transparency and ensure that policymakers, stakeholders, and the public have an accurate understanding of veterans' homes operations, KDVA should adopt the practice of reporting functional occupancy rates and functional capacity alongside certified occupancy and capacity in future legislative reports, stakeholder communications, and budget submissions.

Recommendation 3.2

In future legislative reporting, stakeholder communications, and budget submissions, the Kentucky Department of Veterans' Affairs should adopt the policy of reporting functional occupancy rates and functional capacity in addition to total certified occupancy rates and certified capacity.

Currently, KDVA and its facilities do not formally track or manage waiting lists, resulting in inconsistent practices and limited transparency regarding applicants awaiting placement. To address this gap, the department should promulgate an administrative regulation establishing clear definitions and procedures for managing veteran admissions waiting lists. The regulation should differentiate among three distinct categories: an active list, consisting of applicants awaiting admission due to capacity limitations or pending clinical evaluations related to acuity or behavioral health; an interest list, consisting of individuals who have expressed interest in potential future placement; and a processing list, consisting of applicants who have been approved for admission and are completing the steps necessary to enter a facility. Establishing waiting list management policies in regulation would promote consistency, transparency, and uniformity across all Kentucky veterans' centers and provide a better understanding of veteran long-term care demand in the state.

Recommendation 4.1

The Kentucky Department of Veterans' Affairs should promulgate an administrative regulation that defines and establishes procedures for tracking and managing veterans' admissions waiting lists. The regulation should distinguish three types of waiting lists—an active list, to include applicants awaiting admission due to capacity constraints or pending clinical evaluations related to acuity or behavioral health; an interest list, to include individuals who have expressed interest in future placement; and a processing list, to include applicants who have been approved and are preparing for admission. The administrative regulations should be promulgated by October 1, 2026.

Reliable and consistent admissions data are essential for understanding systemwide access to care, identifying trends in applicant needs, and ensuring that decisions are applied fairly across all Kentucky veterans' centers. However, the study found that current data collection and documentation practices vary significantly across facilities and over time, limiting the ability to assess admissions outcomes, waitlist dynamics, or the extent to which capacity influences access to care. To strengthen oversight, improve accuracy, and support more informed decision making, the Kentucky Department of Veterans' Affairs should improve, formalize, and standardize its data collection, management, and analysis practices related to admissions decisions and waitlist management. As part of this effort, the department should develop a standardized, systemwide database that records admissions decisions using consistent evaluation criteria, captures the complete history of each applicant, and centralizes data management within the Office of Kentucky Veterans' Centers.

Recommendation 4.4

The Kentucky Department of Veterans' Affairs should improve, formalize, and standardize its data collection, management, and analysis practices related to admissions decisions and waitlist management. As part of this effort, the department should develop a standardized, systemwide database that records admissions decisions using consistent evaluation criteria and that captures full case histories. The department should centralize this process within the Office of Kentucky Veterans' Centers and report to the Legislative Oversight and Investigations Committee on the progress of this effort by October 1, 2026.

Although admissions logs do not document how facilities communicate decisions to applicants and families, constituent complaints to legislators indicate that some applicants do not fully understand why they are being denied or deferred. Inconsistent terminology, variable documentation practices, and the absence of standardized communication templates contribute to confusion and frustration, even when decisions are clinically appropriate. To improve transparency and ensure that veterans and their families receive clear and consistent explanations, the Kentucky Department of Veterans' Affairs should promulgate an administrative regulation establishing a standardized process for communicating admissions decisions, including uniform definitions for deferrals and denials, while preserving each facility's flexibility to determine admissions criteria.

Recommendation 4.5

The Kentucky Department of Veterans' Affairs should promulgate an administrative regulation establishing a standardized, systemwide process for communicating admissions decisions across all Kentucky veterans' centers. This regulation should specify the information that must be communicated to applicants in each case and ensure that facilities provide this information in a consistent manner. The administrative regulation should be promulgated by October 1, 2026.

Providing high-quality, consistent, and timely data to the General Assembly is essential for ensuring that Kentucky can meet its long-term care obligations to veterans. Given that there has

been miscommunication between the General Assembly and KDVA regarding occupancy and capacity, that admissions decision data has historically been inadequately tracked, and that waiting lists have not been consistently maintained or managed, it is recommended that KDVA provide the legislature with annual reports on the status of the Kentucky veterans' center system, including data on admissions, denials, deferrals, waiting lists, occupancy, certified and functional capacity, and allocated and filled staffing positions. The General Assembly may wish to consider making the annual reporting of this data statutorily mandated. To ensure that this reporting requirement does not outlast the concerns it is designed to address, the General Assembly may also wish to include a sunset provision.

Recommendation 4.6

The Kentucky Department of Veterans' Affairs should provide the General Assembly with an annual report on the status of the Kentucky veterans' center system. The report should include data on admissions, denials, deferrals, waiting lists, occupancy, certified and functional capacity, and the status of filled staffing positions. This report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026. It should be provided by the same date annually thereafter.

Matter For Legislative Consideration 4.A

The General Assembly may wish to consider making the annual reporting of data and information related to the admissions, denials, deferrals, waiting lists, occupancy, capacity, and staffing of Kentucky veterans' centers statutorily mandated. To prevent this report from being produced after the General Assembly's concerns are resolved, the General Assembly may wish to include a sunset provision.

Establishing An Application Decision Appeals Process

Kentucky veterans' centers currently lack a standardized process for applicants to appeal admissions decisions, resulting in inconsistent practices across facilities and limited transparency for veterans and their families. Establishing a formal, uniform appeals mechanism would provide applicants with a clear and consistent pathway to seek reconsideration. KDVA should establish a formal appeals process for these cases, with the specific structure and administrative procedures developed at the discretion of KDVA and OKVC. At a minimum, the process should create a single, centralized mechanism through which any applicant may appeal a denial or extended deferral and should include participation from facility administrators and the executive director of the Office of Kentucky Veterans' Centers. This approach would improve documentation and oversight while better aligning Kentucky with established best practices in long-term care.

Recommendation 4.7

The Kentucky Department of Veterans' Affairs should establish a formal appeals process for veterans who have been denied admission or deferred for longer than 90 days. The specific structure and administrative procedures for the process should be developed at the discretion of the Kentucky Department of Veterans' Affairs and the Office of Kentucky Veterans' Centers. However, the process should, at a minimum, create a single, centralized mechanism through which any applicant may appeal a denial or an extended deferral; and include participation from facility administrators and the executive director of the Office of Kentucky Veterans Centers. The department should promulgate the appeals process in administrative regulation by October 1, 2026.

Addressing Behavioral Health Care

Rising behavioral health needs among Kentucky veterans are increasingly shaping admissions decisions, staffing demands, and care models across the state veterans' centers. Facilities reported that applicants presenting with significant behavioral health conditions often require specialized care, heightened staffing levels, or secure environments that are not consistently available across the system. Yet Kentucky lacks a comprehensive, systemwide assessment of the scope, trends, and operational impact of these behavioral health challenges. A clearer understanding of these needs is essential for planning future capacity, aligning staffing models, and determining whether additional services or facility types may be warranted. To support informed policymaking, the Kentucky Department of Veterans' Affairs should report to the General Assembly on the scope and impact of the behavioral health challenges facing Kentucky veterans and Kentucky veterans' centers.

Recommendation 4.2

The Kentucky Department of Veterans' Affairs should report to the General Assembly on the scope and impact of the behavioral health challenges facing Kentucky veterans and Kentucky veterans' centers. The report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Growing behavioral health needs among Kentucky veterans are placing increasing pressure on Kentucky veterans' centers, and the state currently lacks a comprehensive plan for how best to address this challenge. To identify effective and sustainable solutions, KDVA should conduct an in-depth analysis, which may require external consultation or significant departmental effort. Accordingly, in its next budget request, the department should seek funding for a study to investigate options for caring for veterans with behavioral health challenges.

Recommendation 4.3

In its next budget request, the Kentucky Department of Veterans' Affairs should request funding for a study to investigate solutions to care for veterans with behavioral health challenges.

Chapter 1

Kentucky Veterans' Centers

Study Charge And Scope

On February 3, 2025, the Legislative Oversight and Investigations Committee (LOIC) directed staff to study the operation and management of Kentucky veterans' centers.

On February 3, 2025, the Legislative Oversight and Investigations Committee (LOIC) directed staff to study the operation and management of Kentucky veterans' centers (state veterans' homes). Staff's objectives were to evaluate how these facilities are organized, funded, and staffed; to investigate concerns related to capacity, occupancy, and waiting lists; to determine whether the facilities are operating within statutory and regulatory requirements; and to identify opportunities to improve the quality and efficiency of veterans' long-term care services in the commonwealth.

In addition to these core objectives, LOIC asked staff to examine two system-level questions regarding both fiscal efficiency and access to care: whether Kentucky is losing revenue by operating below full occupancy, and whether limited bed capacity may be contributing to delays or denials of needed long-term care.

Summary Of Methods

LOIC staff conducted a comprehensive review of the veterans' centers operated by the Kentucky Department of Veterans' Affairs (KDVA). The review encompassed the statutory and regulatory framework governing veterans' care; a 10-year analysis of trends in bed capacity, occupancy, staffing, admissions, and waiting lists; and an assessment of funding sources, revenue, and expenditures. Statewide and national data informed the analysis. In addition, staff conducted multiple interviews with KDVA, each of the five Kentucky veterans' centers, and several other state veterans' affairs offices and state veterans' homes. Staff also completed site visits to Kentucky veterans' centers to evaluate facility conditions.

Key Findings

Although Kentucky's certified occupancy rates are below the national average, using functional operating capacity shows facilities are operating at a higher occupancy than the certified rates suggest.

Occupancy, Capacity, And Revenue. Despite facing challenges, Kentucky veterans' centers provide quality long-term care and skilled nursing services for the commonwealth's veterans. Although Kentucky's certified occupancy rates are below the national average, a more accurate measure of functional operating capacity shows that facilities are operating at substantially higher occupancy levels than the certified figures suggest. Moreover,

analysis found that increases to occupancy do not directly result in increases to revenue. While there are some financial incentives to increasing occupancy rates, these are relatively small and must be put into the context of the cost required to achieve them and other veteran long-term care goals.

Admissions decisions appear to be driven primarily by clinical factors such as physical and behavioral health acuity rather than by capacity. Inconsistent and subjective methods for documenting admissions prevent conclusions about the system's ability to meet long-term needs.

Admissions, Denials, And Demand. Admissions decisions, specifically denials and deferrals, appear to be driven primarily by clinical factors such as physical and behavioral health acuity rather than by capacity limitations.[1] Along with Kentucky's declining veteran population, this indicates that current capacity may be sufficient to meet demand.[2] However, inconsistent and subjective methods for documenting admissions outcomes and maintaining waitlists across Kentucky's veterans' centers prevent definitive conclusions about the system's ability to fully meet long-term care needs.

Operational Challenges. Kentucky veterans' centers do face ongoing challenges related to behavioral health, aging facilities, single-occupancy room transitions, data collection, standardized admissions and waitlist procedures, and capital projects.

Current staffing levels appear sufficient to meet capacity of Kentucky's existing veterans' centers until capital projects are completed.

Staffing. Current staffing levels appear sufficient to meet the functional capacity of Kentucky's four existing veterans' centers until ongoing capital projects are completed and new facilities are operational. Functional capacity accounts for lost certified capacity which lowers the maximum census and reduces corresponding staffing requirements. This results in positions being filled at a high rate relative to actual capacity. However, current veteran demand is uncertain and it is unclear if functional capacity should be increased, which would necessitate more staff.

The veterans' center system could benefit from centralization and greater standardization of operations.

Opportunities For Systemwide Improvement. Systemically, the Kentucky veterans' center system could benefit from centralization and greater standardization of operations, improved communication with applicants, creation of a formal appeals process, facility modernization, decertification of unused beds, a transition toward single-occupancy rooms, and enhanced capacity for behavioral health treatment.

Clarification Of Statutory Language. In addition to these operational findings, staff also identified needed changes to the statutory and regulatory language governing Kentucky veterans' centers which would improve internal consistency and external alignment with federal regulation.

The review found no evidence that current occupancy levels, capacity constraints, staffing limitations, or other operational issues have diminished the quality of care provided.

High Quality Of Care. Despite these challenges, the review found no evidence that current occupancy levels, capacity constraints, staffing limitations, or other operational issues have diminished the quality of care provided. Kentucky's veterans' centers consistently receive quality ratings from the Centers for Medicare and Medicaid Services (CMS) and maintain overall performance scores that exceed national averages.[3]

Outstanding Questions. An important outstanding question is whether current occupancy levels and facility capacity are truly sufficient to meet current and future demand for veterans' long-term care. Applicant demand is not consistently documented across facilities, so underlying need cannot be accurately measured, limiting the state's ability to determine with confidence whether capacity is adequate statewide.

Background

Kentucky Veterans' Centers

Kentucky veterans' centers are long-term facilities operated by the Kentucky Department of Veterans' Affairs (KDVA) through the Office of Kentucky Veterans' Centers (OKVC). They serve Kentucky veterans in need of care due to disease, wounds, age, or other reasons.

Kentucky veterans centers are skilled-nursing and long-term care facilities operated by the Kentucky Department of Veterans' Affairs through the Office of Kentucky Veterans' Centers (OKVC) to serve eligible veterans of the commonwealth. To be an eligible veteran a person must be a veteran with an other-than-dishonorable discharge, a Kentucky resident, and in need of nursing care due to disease, wounds, age, or other reasons. The center must also be able to meet the veteran's specific medical needs.[4] In Kentucky, the maximum and minimum level of acuity for admission are largely left to the discretion of individual facilities and vary by facility and day.

The Kentucky veterans' center system currently consists of four facilities. A fifth facility is expected to open in 2026.

The system currently consists of four operating facilities: the Thomson-Hood Veterans Center (THVC) in Wilmore (285 beds), the Joseph "Eddie" Ballard Western Kentucky Veterans Center (WKVC) in Hanson (156 beds), the Paul E. Patton Eastern Kentucky Veterans Center (EKVC) in Hazard (120 beds), and the Carl M. Brashear Radcliff Veterans Center (RVC) in Radcliff (120 beds). A fifth facility in Bowling Green, the Robert E. Spiller Bowling Green Veterans Center (BGVC) (60 beds), is in development and expected to open in 2026.[5]

Timeline For Kentucky Veterans' Centers

While the first state veterans' home originated in Connecticut in 1864, Kentucky's first veterans' center opened in 1991, and preceded the department that would oversee the centers.[6] The fifth facility is scheduled to be opened in 2026.

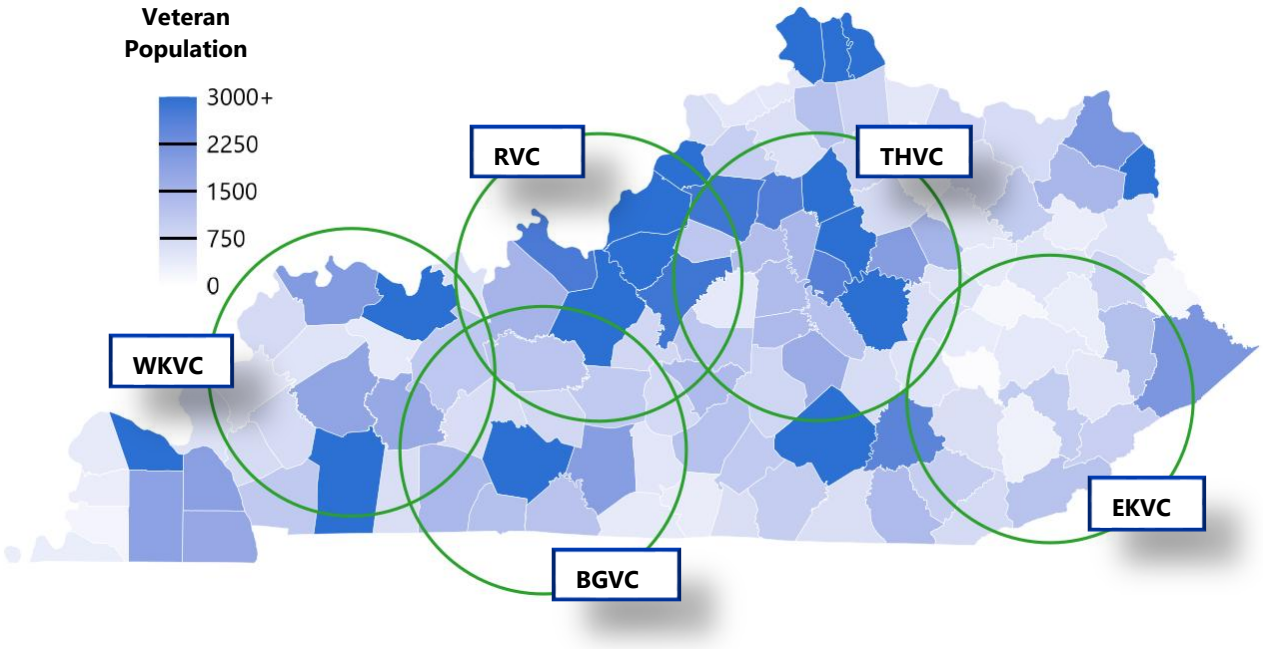
- **1991** - Thomson-Hood Veterans Center in Wilmore, KY admits its first resident, becoming Kentucky's first state-run veterans' nursing home.[7]
- **1998** - Kentucky establishes KDVA as a cabinet-level department governing, among other areas, Kentucky veterans' centers.[8]
- **2002** - Paul E. Patton Eastern Kentucky Veterans Center in Hazard, KY is established and opened to veterans.[9]
- **2002** - Joseph "Eddie" Ballard Western Kentucky Veterans Center opens in Hanson, KY.[10]
- **2013** - The Joseph "Eddie" Ballard Western Kentucky Veterans Center expanded its bed capacity to 156 beds.[11]
- **2017** - Carl M. Brashear Radcliff Veterans Center opens in Radcliff, KY.[12]
- **2022** - Groundbreaking for the Robert E. Spiller Bowling Green Veterans Center in Bowling Green, KY.
- **2026** - Robert E. Spiller Bowling Green Veterans Center projected to open.[13]

Kentucky's Veteran Population

Approximately 267,611 veterans resided in Kentucky as of 2023.

Approximately 267,611 veterans resided in Kentucky as of 2023.[14] Figure 1.A shows how Kentucky's veteran population is distributed across the state and the location of Kentucky's five veterans' centers.

Figure 1.A
Kentucky's Veteran Population Distribution, Veterans' Centers Locations And Veterans' Centers Primary Service Areas



Note: Circles represent a 60-mile radius around the center. WKVC = Western Kentucky Veterans Center; BGVC = Bowling Green Veterans Center; RVC = Radcliff Veterans Center; THVC = Thomson-Hood Veterans Center; and EKVC = Eastern Kentucky Veterans Center.
Source: LOIC staff compiled data on veteran population density and veteran facility coverage areas from information provided by the Kentucky Department of Veterans' Affairs and collected from the American Community Survey 5-year Estimates of 2023 from the U.S. Census Bureau.

Kentucky veterans are most densely concentrated near the Radcliff Veterans Center (RVC) and Thomson-Hood Veteran Center (THVC).

Kentucky veterans are most densely concentrated in central Kentucky near the Radcliff and Thomson-Hood facilities. 45 percent of Kentucky veterans are over the age of 65 and 90 percent are male. Most Kentucky veterans residing in Kentucky veterans' centers served during the Vietnam War era, followed by the Korean War era. The population of veterans in Kentucky decreased by 1.7 percent from 2023 to 2024. Over half of Kentucky veterans served in the Army.[15]

The US Department of Veterans Affairs (VA) sets bed limits for each state. Kentucky's limit is 818 beds. The certified capacity of the Kentucky veterans' center system will reach 741 beds after the fifth facility opens.

Veteran Center Capacity And Occupancy. The US Department of Veterans Affairs (VA) sets bed limits for each state. Kentucky's limit is 818 beds.[16] The maximum licensed and certified capacity of the Kentucky veterans' center system is 681 and will expand to 741 once the veterans' center in Bowling Green is operational. The operational capacity is currently limited to 621 due to a capital project at RVC. In addition, many of these beds exist in rooms that

have been converted from double to single occupancy. Accounting for these unused beds results in a functional capacity of 446 beds. The Kentucky veterans' center system cares for 378 veterans as of May 2025, as shown in Table 1.1.

Table 1.1
Kentucky Veterans' Centers Occupancy
As Of May 2025

Facility Name	Occupancy
Thomson-Hood Veterans Center	142
Eastern Kentucky Veterans Center	96
Western Kentucky Veterans Center	83
Radcliff Veterans Center	57
Bowling Green Veterans Center	Not open
Total	378

Source: Staff compiled list of Kentucky veterans' centers occupancy rates from data provided by Kentucky Department of Veterans' Affairs to the Legislative Oversight and Investigations Committee on May 28, 2025.

Kentucky veterans' centers rely on a blended staffing model that includes merit employees, contracted personnel, and vendor-provided services. For 2025, OKVC established a cap of 854 full-time merit positions and filled 615 positions.

Workforce And Staffing. Kentucky veterans' centers rely on a blended staffing model that includes state merit employees under KRS Chapter 18A, contracted clinical and nonclinical personnel, and vendor-provided services. For 2025, the Office of Kentucky Veterans' Centers established a systemwide cap of 854 full-time 18A positions, tied primarily to available revenue—most notably state general fund support. Of these, 615 positions were filled, resulting in a 72 percent fill rate.[17] Contracted and vendor staff continue to supplement these positions, particularly to cover vacancies, ensure shift coverage, or respond to emergent staffing needs. Their use increased following the COVID-19 pandemic, though KDVA has prioritized transitioning back to 18A staffing since that time.[18]

Staffing levels, like census, declined sharply during the pandemic but have since begun to recover. Staffing reached a ten-year low in 2022 at 432 FTEs and has increased each year thereafter. KDVA attributes much of these gains to the implementation of special entry rates, locality premiums, and increased funding authorized by the General Assembly in 2021 and approved by the Personnel Cabinet and KDVA in 2023.[19]

Admission to a veterans' center begins with an application package, which are reviewed for eligibility and clinical appropriateness.

Admissions And Waiting Lists. Admission to a Kentucky veterans' center generally begins with an application package submitted by the veteran, a family member, or a referring provider.

Applications are reviewed for eligibility and for clinical appropriateness based on the veteran's needs and unit availability. When a suitable bed is not immediately available, the applicant's needs require additional vetting, or the applicant is not personally ready to enter the facility, applicants may be placed on a waiting list.[20]

To be admitted, an applicant must be a Kentucky resident, a military veteran, and in need of long-term care. Each center has broad discretion over admission decisions.

KRS Chapter 40 and 17 KAR 3:040 set baseline standards for admissions procedures. Specifically, that the applicant is a Kentucky resident, a military veteran, and is in need of long-term care. Beyond these guidelines, each center's administration has broad discretion over admissions decisions. Admissions staff evaluate all applicants to determine that they are in need of long-term care, whether the facility can provide the level of care needed by the applicant, whether the facility can accommodate the applicant's behavioral conditions, and whether there is adequate staffing and capacity to care for the applicant.[21]

Admissions staff then decide to admit, deny, or defer. Individuals that are deferred are placed on an informal waiting list. This can be for a variety of reasons including physical or behavioral health evaluation or capacity limitations. Veterans may also request to be placed on waiting lists in order to queue for future admission. There is no formal regulatory or statutory policy defining waiting list procedures, therefore each veterans center has broad discretion is these matters.

Governance And Funding

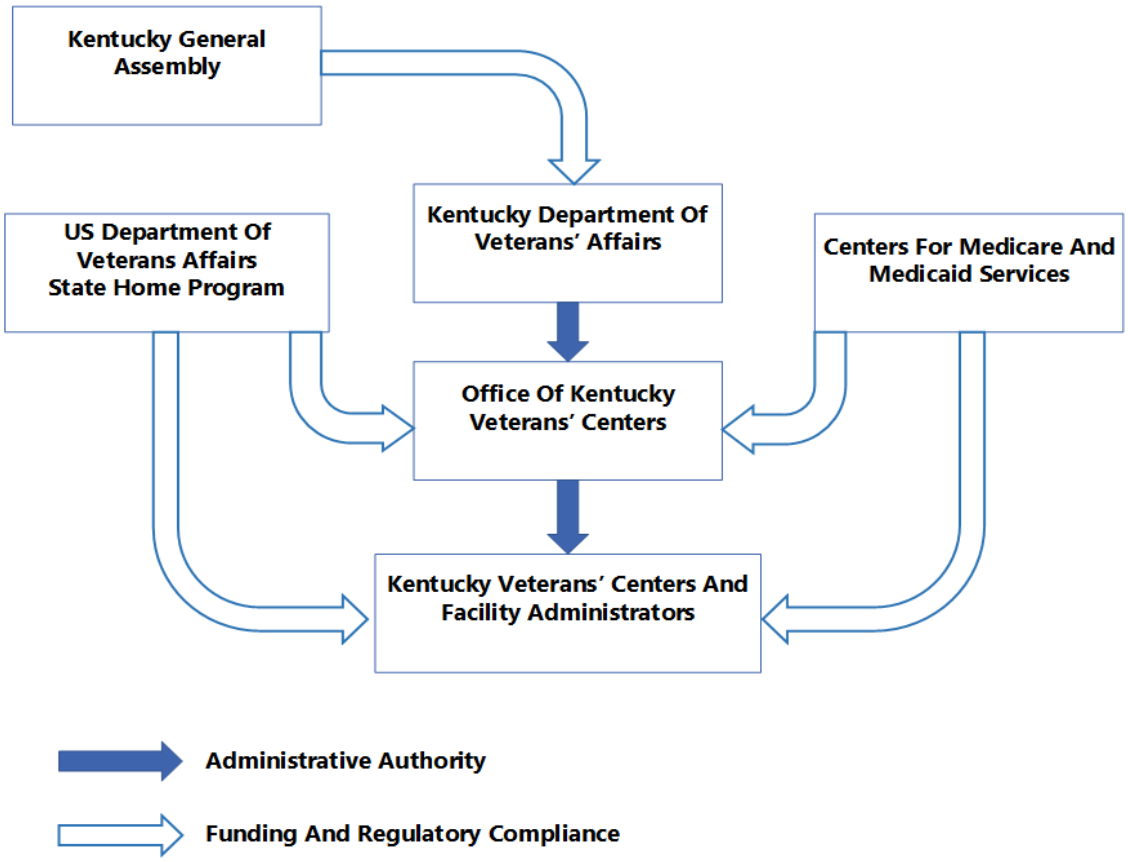
As seen in Figure 1.B, Kentucky's veterans' centers are overseen by entities at the state and federal level. The Kentucky Department of Veterans' Affairs is the primary agency for the centers but funding and requirements also originate with the federal Department of Veterans Affairs and the Centers for Medicare and Medicaid Services. Federal assistance does not support the full cost of the centers and the General Assembly has traditionally filled the funding gap.

KDVA establishes policy and ensures compliance with statutes, regulations, and federal program requirements. The veteran centers system is large decentralized. KDVA sets broad expectations and provides oversight but individual centers operate with substantial day-to-day autonomy.

Kentucky Department Of Veterans' Affairs. KDVA is the cabinet-level agency responsible for establishing policy and ensuring compliance with relevant statutes, regulations, and federal program requirements. The Kentucky veterans' centers system is largely decentralized. While KDVA sets broad expectations and provides oversight, individual centers operate with substantial day-to-day autonomy over staffing, scheduling, vendor relationships, admissions coordination, and purchasing and

operational practices within state requirements. Broad admissions criteria and related procedures are set under KDVA's statutory and regulatory authority in KRS 40.320, 40.325, and 17 KAR Chapter 3, with center-level teams managing day-to-day bed placement within those parameters. Consistent with the system's decentralized design, individual centers retain discretion over local scheduling, vendor performance, and other tactical decisions, while KDVA maintains cabinet-level policy and compliance oversight. Figure 1.B illustrates the overall governance and funding structure of Kentucky veterans' centers, including the relationships among KDVA, the Office of Kentucky Veterans' Centers, individual facilities, and federal partners.

Figure 1.B
Governance And Funding Structure
For Kentucky Veterans' Centers



Source: Legislative Oversight and Investigations Committee staff review of KRS 40; 17 KAR Chapter 3; 42 CFR pt. 59; 38 CFR pt. 53; and 38 CFR pt. 51.

Within KDVA, OKVC operates state veterans' homes and provides systemwide operational leadership.

Office Of Kentucky Veterans' Centers. Within KDVA, OKVC operates the commonwealth's state veterans' homes and provides

systemwide operational leadership. OKVC's executive director reports within KDVA and oversees facility operations, budgets, staffing initiatives, and program goals. The office is also responsible for completing budget requests and distributing state funds. The Office was established by KRS 40.325.

Each center has a similar management structure. A licensed administrator oversees each facility reports to the executive director of OKVC. Facilities also have a director of nursing and subject matter experts.

Individual Facility Administration. While operations differ at each center, they have similar management structures. A licensed administrator oversees each facility and reports to the executive director of OKVC. Facilities also have a director of nursing that oversees medical care for the residents. Facilities also have subject matter experts that communicate between facilities to share information and experiences.

The VA certifies state veterans' homes and provides financial assistance. All Kentucky veterans' centers are certified by the Centers for Medicare and Medicaid Services (CMS).

The US Department Of Veterans Affairs And The Centers For Medicare And Medicaid Services. The US Department of Veterans Affairs interacts with state veterans' homes through multiple channels: per-diem payments for eligible residents; clinical quality oversight and recognition of state survey processes; capital grant programs for construction and renovation; and eligibility, certification, and reporting frameworks that states must follow to maintain participation and eligibility for funding. Additionally, Kentucky veterans' centers are all Centers for Medicare and Medicaid Services (CMS) certified so that eligible residents can qualify for Medicare and Medicaid reimbursement. As a result, they must participate in a federal quality rating system administered by CMS. They must also comply with federal participation requirements in areas such as staffing, resident rights, quality of care, infection control, and physical environment. CMS requires that the Cabinet for Health and Family Services conduct periodic health and safety surveys to determine compliance. CMS also reports all facilities survey results and quality metrics to the public.[22]

Veterans' centers are funded through state general fund appropriations, federal VA per diem revenue, Medicaid reimbursements, and resident cost-sharing.

Funding For Kentucky Veterans' Centers. Kentucky veterans' centers are funded through a combination of state general fund appropriations; federal VA per diem revenue; Medicaid reimbursements for eligible residents; and resident cost-sharing in the form of private pay or third-party coverage. The precise mix of pay amounts and sources varies by resident and by facility based on factors such as resident acuity, service-connected disabilities, and facility location.[23]

In FY 2024, the General Assembly appropriated approximately $31 million in general fund support to KDVA. The department also received around $67 million in revenue from Medicaid and

Medicare reimbursements, federal VA per diem payments, resident payments, and private insurance. Total revenue for the department was approximately $98 million, of which $88 million was allocated to the OKVC for the operation of Kentucky veterans' centers.[24]

Major Objectives

This study had 10 major objectives.

This study had 10 major objectives.

- Review the state statutory and regulatory framework governing Kentucky veterans' centers and assess alignment with KDVA administrative regulations, state budget language, and state statute.
- Review the federal statutory and regulatory framework applicable to state veterans' homes and assess alignment with the federal Department of Veterans Affairs and the Centers for Medicare and Medicaid Services standards.
- Examine the state and federal funding mechanisms for the Kentucky state veterans' centers and report on the centers' revenue and expenditures.
- Analyze census and capacity at Kentucky veterans' centers to evaluate occupancy rates and understand how physical design, functional capacity, staffing, and ongoing capital projects influence the system's ability to operate efficiently and provide care.
- Determine whether current occupancy rates and facility capacity are denying Kentucky veterans access to care or limiting potential state revenue.
- Evaluate staffing levels and staffing policies at Kentucky veterans' centers to assess workforce shortages potential impacts on capacity.
- Examine admissions and denial processes to determine whether they are standardized, transparent, and consistently applied across veterans' centers.
- Assess the current status of admissions decisions and waiting lists to determine current demand for veteran long-term care and evaluate if this demand is unmet due to capacity constraints.
- Evaluate facility operational and modernization needs, including the transition from double- to single-occupancy rooms, ongoing capital projects, and facility renovations.
- Assess major challenges facing Kentucky veterans' centers and recommend solutions based upon best practices.

Major Conclusions

This study has 18 major conclusions.

This study has 18 major conclusions:

- Kentucky veterans' centers are currently operating at 56 percent of certified capacity, which is below the national average. However, when adjusting for functionally available beds by removing unused beds pending decertification and those temporarily unavailable due to construction projects, the adjusted occupancy rises to 85 percent, exceeding the national average.
- Current capacity and occupancy levels do not appear to be primary drivers of admissions denials, deferrals, or waitlist placements. Instead, the main factors are applicants whose behavioral or physical health needs exceed what veterans' centers can safely accommodate, along with applicants choosing to forgo admission.
- Application denials due to behavioral health appear to be the primary driver of applicant or constituent frustration with admissions and waiting list processes.
- KDVA should improve, formalize, and standardize their data collection, management, and analysis capabilities with respect to admissions decisions and waitlist management.
- KDVA should formally define waiting lists and distinguish active lists, where applicants are waiting due to capacity constraints or acuity or behavioral health evaluations, from interest lists, where applicants have placed their names on lists for future consideration.
- Capital projects, staffing limitations, and inaccurate reporting of true capacity are the primary factors leading to low occupancy rates at Kentucky veterans' centers.
- Certified but unused beds are misrepresenting occupancy data, which may cause negative outcomes for Kentucky veterans' centers by keeping occupancy rates lower. Lower occupancy rates make bed holds impossible, building new facilities more difficult, and miscommunication with stakeholders more likely.
- KDVA should report both certified and functional capacity and occupancy rate in order to properly communicate these to applicants, the General Assembly, and other stakeholders.
- KDVA should decertify beds at Thomson-Hood Veterans Center and Western Kentucky Veterans Center that are no longer in use due to transition from double- to single-occupancy rooms.
- KDVA should develop a plan for transitioning all veterans long-term care facilities to single-occupancy rooms in order to improve resident quality of life, consistency of resident

experience across centers, health outcomes, and infection control.

- Quality of care for veterans in Kentucky veterans' centers is higher than the national average.
- The capital project to replace the HVAC system at Radcliff Veterans Center has caused capacity constraints for the Kentucky veterans' center system. Given concerns surrounding the project, specifically the replacement outside of warranty and soon after installation, the project should be reviewed by the Auditor of Public Accounts or the Office of the Attorney General.
- The Thomson-Hood Veterans Center would benefit from continued modernization efforts.
- Some Kentucky veterans' centers report difficulty filling staffing positions or personnel limits that are too low. The Kentucky Personnel Cabinet and KDVA should work to evaluate the need to maintain or expand staffing incentives and personnel caps for some Kentucky veterans' centers.
- The Kentucky veterans' center system could benefit from centralization of some operations and standardization of some policies and procedures.
- Current statutory and regulatory language governing state veterans' centers uses inconsistent terminology and could cause confusion. The language should be revised for consistency and alignment with federal standards. The study recommends revising "veterans' centers" to "veterans homes."
- Kentucky veterans' centers require general fund support for every resident. While the centers are reimbursed for medical expenditures, the reimbursements are insufficient to cover the cost of care. Increasing the number of residents housed at the centers would likely require additional financial support from the General Assembly.
- Inconsistent and subjective methods for documenting admissions outcomes and maintaining waitlists across Kentucky veterans' centers prevent definitive conclusions and accurate evaluations of underlying need. As a result, it limits the state's ability to determine with confidence whether the system is fully meeting veteran demand for long-term care.

Methodology

For this review, staff used a mixed-methods approach that combined document review, quantitative data analysis, interviews, site visits, and statutory and regulatory analysis.

The study reviewed the facilities and operations of Kentucky veterans' centers from 2015 to 2025. Staff used a mixed-methods approach that combined document review, quantitative data analysis, interviews, site visits, and statutory and regulatory analysis.

Staff conducted an extensive review of documents and records relevant to the operation and oversight of Kentucky's state veterans' centers. This included reviews of Kentucky statutes and administrative regulations governing KDVA and state veterans' homes, the federal statutory and regulatory requirements from the VA and CMS, VA per diem rules and design guidance, and CMS nursing facility requirements and reimbursement structure. Staff also reviewed KDVA budget requests and financial statements, state budgets, and Kentucky veterans' center facility-level documents including admissions logs, census records, staffing reports, and capacity documentation.

Staff conducted interviews with KDVA leadership and facility administrators, admissions personnel, and caregivers at each Kentucky veterans' center. Additionally, interviews were held with veterans' affairs departments from multiple other states and the National Association of State Veterans Homes. Staff also conducted site visits to Kentucky veterans' centers to evaluate operations and facility conditions.

Staff reviewed census, capacity, and occupancy patterns for each facility from 2015 through 2025, along with admissions, denials, and waiting list information provided by the centers. Staffing data were examined to assess workforce conditions, including staffing levels, classifications, vacancy rates, the use of vendor and contract staff, and compensation practices. Financial data were reviewed to evaluate the centers' revenue sources, such as VA per diem payments, CMS reimbursement, private pay, and state general fund support, and to understand expenditures. Staff also analyzed the financial implications of operating at different occupancy levels and capacities.

Structure Of Report

Chapter 2 discusses findings and recommendations related to individual veterans' centers.

This report is organized into four chapters. Chapter 2 discusses findings and recommendations related to the individual Kentucky veterans' centers. It reviews each of the five facilities and discusses the characteristics of and challenges facing each. It provides recommendations related to modernization, capital projects, staffing, and the decertification of unused beds. The chapter also includes a discussion of the legal framework governing Kentucky long-term care for veterans.

Chapter 3 reviews occupancy and capacity from the view of the entire statewide system.

Chapter 3 shifts to the statewide system more broadly and examines occupancy and capacity. It provides findings and recommendations for transitioning to single-occupancy rooms, reporting occupancy rates, staffing, and reviews the funding mechanisms for veterans' centers in order to evaluate whether occupancy and capacity are limiting revenue.

Chapter 4 reviews access to care, staffing, and admissions procedures.

Chapter 4 examines veterans' access to care in order to evaluate whether capacity and occupancy limitations are limiting veteran access. It provides findings and recommendations regarding admissions procedures, waiting list management, communication processes, reporting standards, the behavioral health challenge facing Kentucky veterans' care, and the creation of a formal appeals process. It also reviews staffing and quality of care. The report includes 18 recommendations and 4 matters for legislative consideration.

Chapter 2

Kentucky Veterans' Centers: Facility Characteristics And Challenges

Kentucky operates four veterans' centers for long-term care of veterans, with a fifth under construction. Each center serves different populations, operates under different models, and faces different challenges.

Kentucky operates four state veterans' centers for the long-term care of veterans, the Thomson-Hood Veterans Center in Wilmore, the Paul E. Patton Eastern Kentucky Veterans Center in Hazard, the Joseph "Eddie" Ballard Western Kentucky Veterans Center in Hanson, and the Carl M. Brashear Veterans Facility in Radcliff. A fifth facility is currently under construction in Bowling Green.[25] Each center is unique. They serve different regional populations and operate within distinct infrastructure environments and facility models. For example, Thomson-Hood and Eastern Kentucky reflect older institutional designs that resemble medical settings; Western Kentucky combines innovative residential-style residences with a central building; and Radcliff and Bowling Green employ a modern small-house model centered on private suites surrounding home-like common areas.[26]

The facilities also face different challenges. Some of these challenges deal with systemic issues such as staffing and occupancy. For example, EKVC reports stable staffing and low vacancy rates, while WKVC experiences staffing shortages that consistently lower occupancy rates. Other challenges are related to the physical infrastructures that differ among the facilities. THVC is an aging facility with an outdated model which is transitioning from double- to single-occupancy rooms and in need of modernization efforts, while RVC is undergoing a major infrastructure project that has cut its operating capacity in half.[27]

Moreover, each facility maintains considerable autonomy and discretion in managing day-to-day operations, including admissions decisions, staffing strategies, and care practices. Administrators and their staff determine how to interpret and apply admissions criteria, assess applicants' clinical and behavioral suitability, and decide when to defer or deny admissions based on a facility's capacity to meet specific care needs. Each center also develops its own internal staffing models and scheduling practices in response to local labor market conditions.[28] This operational flexibility allows centers to tailor services and respond quickly to local needs but can also result in inconsistencies in admissions practices, data management, and operations across the statewide system.

Despite their differences, all facilities operate under the same legal and financial framework, and are overseen by the Office of Kentucky Veterans Centers within the Kentucky Department of Veterans' Affairs.

Despite their unique attributes, all Kentucky veterans' centers operate within the same overarching legal and financial framework. Each facility is governed by the statutory and regulatory provisions established in KRS Chapter 40 and 17 KAR 3:042; is overseen by the Kentucky Department of Veterans' Affairs; and relies on a consistent blend of federal VA per diem reimbursements, Medicaid payments, and state appropriations to support operations. Another important commonality is all staff and administrators interviewed or encountered during LOIC site visits demonstrated a strong commitment to caring for Kentucky's veterans and were eager to assist with this study in the hope that it would benefit the veterans they serve. This was also true of KDVA and Office of Kentucky Veterans' Centers staff who were responsive and transparent throughout this project.

This chapter's opening section examines the common legal and financial frameworks that govern and provide funding for the Kentucky veterans' center system as a whole. It includes recommendations for clarifying and modernizing statutory and regulatory language. The remainder of the chapter then discusses each facility individually, reviewing its operations, infrastructure, unique challenges, and specific recommendations for improvements. The chapter includes seven recommendations and three matters for legislative consideration.

Governing Framework For Kentucky Veterans' Centers

Veterans' centers laws and regulations are established by the Federal Department of Veterans Affairs the Centers for Medicaid and Medicare Services, KDVA, and the Cabinet for Health and Family Services (CHFS).

Several laws and regulation provide a framework for governing and oversight of the long-term care of Kentucky's veterans. Primarily these are presided over by the Federal Department of Veterans Affairs, the Centers for Medicaid and Medicare Services, KDVA, and the Cabinet for Health and Family Services (CHFS). Table 2.1 provides an overview of this framework and they are discussed in more detail throughout this chapter.

Table 2.1
State And Federal Requirements Governing
Veterans Long-Term Care Facilities In Kentucky

Governing Area	Governance Language	Level Of Governance	Governance Citation
Occupancy and capacity	There is a limit of 818 beds eligible for VA construction grants, unless exemption granted.	VA	38 CFR sec. 59.40
Occupancy and capacity	Facilities must be licensed, report bed capacity and changes to CHFS-OIG.	State	902 KAR 20:008
Expansion and new facilities	State veterans long-term care facilities are exempt from Certificate of Need requirements.	State	KRS 216B.020
Expansion and new facilities	New state veterans long-term care facilities are only to be considered when combined occupancy is greater than 80 percent. Future beds are to be dedicated to establishing a facility in Magoffin County.	State	*Acts Of The 2024 Regular Session*, ch. 175, p 1806
Expansion and new facilities	VA funds up to 65 percent of new or renovated state veterans' home projects costing at least $400,000, based on need and veteran population.	VA	38 CFR sec. 59.80
Physical requirements	Resident rooms limited to maximum of 4 occupants; they must meet design, space, and safety codes.	VA and CMS; State	42 CFR sec. 483.90; 38 CFR sec. 51.200; 902 KAR 20:310
Bed-hold per diem	The VA pays per diem is for up to 10 hospital days and 12 non-hospital days per year if occupancy at least 90%.	VA	38 CFR sec. 59.40
Bed-hold per diem	Hold requires written bed-hold notice, policies, and same or first available room upon return.	CMS	42 CFR sec. 483.15
VA per diem recognition	Facilities are recognized as eligible for VA per diem if they have 20 or more residents or operate at 50% or higher capacity.	CMS	38 CFR sec. 51.31

Note: VA = Federal Department of Veterans Affairs; CMS = Centers for Medicaid and Medicare Services; and CHFS-OIG = Cabinet for Health and Family Services-Office of the Inspector General.
Source: Staff compilation of *Kentucky. General Assembly. Acts Of The 2024 Regular Session*, ch. 175, p, 1806; KRS 216B.020; 902 KAR 20:008 and 902 KAR 20:310; 38 CFR sec. 51.31, 38 CFR sec. 59.40, 38 CFR sec. 59.80, 42 CFR sec. 483.15, and 42 CFR sec. 483.90.

Kentucky statutes and regulations refer to these facilities as both "homes" and "centers." This report uses "center" to refer to a specific facility and "home" to refer to veterans' long-term care abstractly.

Kentucky law mandates "there shall be established and maintained in the Commonwealth of Kentucky state veterans' nursing homes to provide long-term care to veterans who are residents of Kentucky."[29] Statute places Kentucky's state veterans' homes under the authority of KDVA, specifically within the Office of Kentucky Veterans' Centers.[30] It directs KDVA to operate these facilities and authorizes it to promulgate administrative regulations necessary to ensure compliance with applicable state and federal statutes and regulations.[31] "Homes" and "centers" are used interchangeably in Kentucky statute and regulation. For the purpose of this report, "center" will refer to a specific Kentucky veterans' facility and "home" will refer to veterans' long-term care in the abstract.

While the KDVA is responsible for establishing and operating veterans long-term care facilities, participation in federal programs significantly enhances their capacity and capabilities. All state veterans' homes in the United States, including those in Kentucky, receive oversight and funding from the VA.[32] Kentucky has elected to have its veterans' homes certified by CMS in order to qualify for Medicaid and Medicare reimbursement.[33]

VA Basic And Prevailing Rate Per Diems

The VA provides two types of daily per diem payments to state veterans' homes to offset the cost of care for residents. The basic rate is a flat rate to supplement the cost of care. The prevailing rate covers all or most of the cost of care but is only available to veterans with a service-connected disability rating of 70 percent or higher.

The basic per diem rate was $144.10 per day in 2025. The prevailing is based on cost reports from centers and averaged $513.13 in 2025.

The VA provides daily per diem payments to state veterans homes to help offset the cost of care for eligible residents. Two primary reimbursement structures exist: the basic rate and the prevailing rate.[34] The basic rate per diem for 2025 ($144.10 per day) is a flat national payment intended to supplement, rather than fully cover, the cost of care. It applies equally across all states and facilities and represents only a portion of a facility's daily operating expense or a resident's total cost of care.[35]

By contrast, the prevailing rate per diem is designed to cover all of the cost of care for certain veterans for whom the VA assumes complete financial responsibility. This rate applies to veterans who require nursing care due to a disability injury that occurred during service. This rate also applies to veterans with a military service injury resulting in a disability rating of 70 percent or higher with an unrelated condition that requires nursing care.[36] Under this rate, instead of paying standard supplement, the VA reimburses the cost of care up to a maximum allowable "prevailing" amount, which is designed to reflect the maximum rate payable in the geographic area for nursing-home care. In the case of Kentucky veterans' centers this averaged out to $513 per day across all facilities. Table 2.2 presents the prevailing rate for each Kentucky veterans' center.

Table 2.2
The US Department Of Veterans Affairs Prevailing Rate Per Diem For Kentucky Veterans' Centers
FY 2025

Facility	Prevailing Rate Per Diem
Thomson-Hood Veterans Center	$532.60
Eastern Kentucky Veterans Center	491.95
Carl M. Brashear Radcliff Veterans Center	536.00
Western Kentucky Veterans Center	491.95
Average	$513.13

Source: US Department of Veterans Affairs. Geriatrics and Extended Care: State Home Per Diem Program. October 21, 2025. Web.

VA And CMS Oversight

Kentucky operates 4 of the 153 state veterans' homes in the United States. The VA provides federal oversight and CMS reimbursement comes with additional requirements.

There are 153 state veterans' homes nationwide, including the 4 currently operating in Kentucky. These homes serve approximately 14,500 veterans.[37] The facilities are owned and operated by individual states but the VA provides federal oversight and many receive funding through CMS reimbursement which comes with additional oversight.[38]

To participate in the VA State Veterans Home program, a home must be inspected and certified by the VA. Certification is required for initial operation and federal funding.

The VA's Geriatrics and Extended Care program office administers the State Veterans Home program nationally, ensuring that facilities meet federal standards for quality of care, resident safety, and eligibility for per diem payments. To participate in the program, a state veterans' home must be inspected and certified by the VA under the authority of 38 USC 1741–1745 and 38 CFR pt. 51. Certification is required both for initial operation and for ongoing receipt of federal per diem funding.

The VA conducts annual inspections of each certified facility, evaluating compliance with clinical care standards, staffing requirements, infection control, medication management, and resident rights. These inspections are separate from those conducted by CMS for facilities that are dual-certified for Medicaid or Medicare reimbursement.

CMS-certified homes are subject to dual oversight from CMS and the VA. As of 2022, 76 percent of US veterans' homes operate as skilled nursing facilities certified by CMS to participate in Medicaid and Medicare. The Nursing Home Reform Act of 1987 established national standards for nursing home care.

CMS-certified state veterans' homes are subject to dual oversight from both CMS and the VA. As of 2022, 76 percent of state veterans' homes nationwide, including all veterans' centers in Kentucky, operate as skilled nursing facilities that are certified by the CMS to participate in Medicaid and Medicare.[39] These facilities are subject to additional federal oversight under the Nursing Home Reform Act of 1987. This law established national standards for nursing home care and created a system of federal inspections, deficiency citations, and enforcement actions carried out by the CMS.[40]

The VA advises in the construction and modernization of state veterans' homes and funds up to 65 percent of approved construction or renovation costs. It also maintains a national reporting system for census, staffing, and financial data.

In addition to regulatory oversight, the VA plays an advisory role in the construction and modernization of state veterans' homes. Through the State Home Construction Grant Program, the VA reviews and approves architectural designs, ensures compliance with federal life-safety codes, and funds up to 65 percent of approved construction or renovation costs. The VA also maintains national reporting systems that collect resident census, staffing, and financial data from each facility.

Clarifying Statutory And Regulatory Language Facilities

Kentucky law and regulation uses internally inconsistent terminology that differs from federal standards for veterans' facilities.

Kentucky law and regulation use terminology that is sometimes internally inconsistent, and differs with federal standards when referring to the state's veterans long-term care facilities. Across Kentucky's legal framework, the terms "veterans' centers," "veterans' homes," and "nursing facilities" all appear; sometimes they appear within the same statutory or regulatory context and all in reference to the same facilities.

Kentucky's legal language describes these facilities as veterans' nursing homes, veterans' centers, veterans' homes, nursing homes, and nursing facilities.

For example, KRS 40.320 declares the General Assembly's purpose "to authorize the establishment of state veterans' nursing homes," and KRS 40.325 then both establishes those state veterans' nursing homes and creates the Office of Kentucky Veterans' Centers to operate them while referring to them in this context as *centers*. KDVA's own public-facing materials likewise refer to *state veterans centers* and *veterans homes*, interchangeably. Further, the administrative regulation that implements these statutes, 17 KAR 3:042, is titled "Eligibility requirements for state veterans' nursing homes" but tells applicants they must be eligible for admission "to a Kentucky Veterans' Center," further illustrating the mixed terminology. These contrast with CHFS' licensure terminology, under which these same facilities fall under the general long-term-care category for "nursing facility" (902 KAR 20:300).

At the federal level, the VA uses *state veterans homes* to describe state-owned and operated nursing homes that provide long-term care to veterans. The Kentucky Department for Medicaid Services similarly uses *state veterans home* in certifications.

At the federal level, the VA uses *state veterans home* to describe state-owned and operated nursing homes that provide long-term care to eligible veterans.[41] The VA uses this term consistently across its grant, per diem, and certification regulations.[42] The Kentucky Department for Medicaid Services similarly uses *state veterans home* terminology in applying certification and reimbursement standards.[43] Additionally, a review of other state statutory and regulatory language found that most states refer to long-term veterans' care facilities as state veterans' homes. The National Association of State Veterans Homes Administrators (NASVH) has also adopted this terminology.[44]

Kentucky's use of overlapping terms creates ambiguity when comparing to the standardized federal terms that help fund the facilities. This inconsistency could complicate coordination with federal agencies and cause confusion.

Kentucky's use of several overlapping terms creates ambiguity in statute, regulation, and reporting because the federal VA and CMS have adopted the term *state veterans home* to designate facilities eligible for VA per diem and Medicaid certification. This inconsistency could complicate coordination with federal agencies, impact funding alignment, and cause confusion among veterans, families, and oversight entities. Standardizing Kentucky's language to match federal usage would enhance transparency,

ensure alignment with VA and CMS program requirements, and strengthen the legal and administrative coherence of Kentucky's veterans' long-term care system.

Recommendation 2.1

Recommendation 2.1

The Kentucky Department of Veterans' Affairs should revise their regulatory language to replace references to "veterans' centers" with "veterans homes" to improve consistency and align Kentucky's language with federal long-term care language from the US Department of Veterans Affairs and the Centers for Medicare and Medicaid Services.

Matter For Legislative Consideration 2.A

Matter For Legislative Consideration 2.A

The General Assembly may wish to revise their statutory language, specifically KRS Chapter 40, to replace references to "veterans' centers" with "veterans homes" to improve consistency and align Kentucky's language with federal long-term care language from the US Department of Veterans Affairs and the Centers for Medicare and Medicaid Services.

Governing Capacity And Occupancy

State and federal regulation govern capacity and occupancy at veterans' centers. Capacity indicates the number of beds a facility is licensed or certified to operate which defines the maximum number of residents it may accommodate.[a] Occupancy, on the other hand, is the proportion of those beds that are filled by residents at any given time. Under VA regulations, a veteran center's occupancy rate is calculated by dividing the total number of residents on a given day by the facility's federally certified bed limits.[45] These federal bed limits create a maximum cap on Kentucky veterans' centers capacity.

Federal law requires the VA to prescribe a maximum number of beds to fund through federal per diems and construction grants. Kentucky's current maximum capacity is 818 beds.

Federal VA Certified Bed Limits. Federal law requires that the VA prescribe a maximum number of beds that it will fund through federal per diems and the State Home Construction Grant Program.[46] This limit is currently based on the projected demand as calculated by a 10-year rolling projection.[b] [47] Kentucky's

[a] For a Kentucky-specific definition, see KRS 142.301, which defines *total bed capacity* as "the combination of licensed nursing home beds, licensed nursing facility beds, and licensed intermediate-care facility beds."

[b] The current federal VA funded bed limit is based on projected demand for beds among veterans aged 65 and older residing in a state.as determined ten years after enactment of the Veterans Millennium Health Care and Benefits Act.

current VA-certified maximum capacity is 818 beds.[48] The state cannot receive VA construction grants for new or expanded veterans care facilities exceeding this limit unless granted an exception. States may request an exception for additional beds but the VA must assess the need as significant in order to approve it.[c] [49] The VA also only provides reimbursement for certified beds, making it virtually impossible to operate veterans' centers without certification. As a result, capacity changes are heavily influenced by the VA.[50]

All veterans' centers in Kentucky must be licensed by CHFS to operate. All facilities report their number of certified beds; any proposed changes require a review by the Office of Inspector General.

Kentucky Licensure Requirements. All health facilities in Kentucky, including veterans' long-term care facilities, must be licensed by CHFS to operate.[51] All facilities must report their number of licensed (certified) beds and any proposed changes to this number necessitate a review by Office of Inspector General (OIG). Facilities cannot operate above the approved and certified number of beds without a license modification.[52]

While the VA has certified Kentucky for 818 beds statewide, CHFS has certified Kentucky veterans' care facilities for a total of 741 beds.

While VA bed limits set how many beds Kentucky may receive federal support for under VA programs, the state CHFS license sets how many beds an individual facility may operate under state health law. As noted above, the Federal VA has certified Kentucky for 818 beds statewide. Meanwhile, CHFS has certified Kentucky veterans care facilities for a total of 741 beds. This includes the 60 beds at BGVC which has not yet opened.[53]

CHFS requires licensed long-term care facilities to submit annual utilization surveys that collect data on bed use and census

As part of the licensure process, CHFS requires licensed Kentucky's long-term care facilities to submit annual utilization surveys.[54] These surveys collect data on licensed beds, beds in operation, beginning census, admissions, and occupancy percentages.[55] All of Kentucky's veterans' centers participate in this annual survey and the data collected is published annually by CHFS.[56] Kentucky health facilities generally require a Certificate of Need authorization before making a substantial change in bed capacity.[57] [d] However, state law exempts Kentucky veterans' centers from this requirement.[58]

[c] States may request additional beds by documenting that a veteran must travel at least 2 hours from a population center suitable for a veteran's home to the nearest facility; VA approval is discretionary.

[d] *Certificate of need* is defined in KRS 216B.015 as an authorization by CHFS "to acquire, to establish, to offer, to substantially change the bed capacity, or to substantially change a health service."

Kentucky Veterans' Centers Background And Findings

This section focuses on veterans' centers in Kentucky individually and reviews their unique features and challenges. Additionally, it provides specific findings and recommendations for the facilities. Table 2.3 lists each facility, its capacity and occupancy information, its long-term care model, its room type, availability of secured units for the care of patients with behavioral health issues, and some notes on the current issues facing each facility. The current issues are discussed in more detail later.

Table 2.3
Kentucky Veterans' Centers Characteristics
As Of May 2025

Facility Name	Occupancy/ Capacity	Facility/ Model	Room Type	Secured Units	Facility Characteristics
Thomson-Hood Veterans Center	142/285	Institutional/ Medical	Unofficially single-occupancy	Yes	• Oldest KY veterans center but modernization efforts are ongoing • Has certified beds that are no longer in use due to conversion from double- to single-occupancy rooms
Paul E. Patton Eastern Kentucky Veterans Center	96/120	Institutional/ Medical	Officially double-occupancy	Yes	• Highest occupancy rate among KY veterans' centers • Most stable staffing among KY veterans' centers • Most challenging KY center to convert to single-occupancy rooms
Joseph "Eddie" Ballard Western Kentucky Veterans Center	83/156	Cottage/ Residential	Mixed	Yes	• Includes small cottages and central building for a hybrid model • Has experienced the most staffing challenges • Has certified beds that are no longer in use due to conversion from double- to single-occupancy rooms
Carl M. Brashear Radcliff Veterans Center	57/120	Small home/ Community	Officially single-occupancy	No*	• Capacity limited to 50 percent due to an HVAC replacement project • Developed with modern long-term care "small homes" model which includes community neighborhoods and single-occupancy rooms
Robert E. Spiller Bowling Green Veterans Center	-/60	Small home/ Community	Officially single-occupancy	No	• Is projected to open in the first quarter of 2026 • Developed with modern veteran long-term care "small homes" model which includes community neighborhoods and single-occupancy rooms

*This facility will have a secure unit once HVAC renovations are complete.
Source: LOIC staff compiled data and findings for Kentucky veterans' centers. Compiled from KDVA data requests, federal VA requests for information, facility site visits, and interviews.

Kentucky veterans' centers employ several facility models reflecting different eras of long-term care design. The traditional institutional or medical model, used at Thomson-Hood and Eastern Kentucky Veterans Centers, resembles a hospital layout with rooms on each side of long corridors and centralized nursing stations. The cottage or household-hybrid model, used at Western Kentucky Veterans Center, combines small residential cottages with a central support building. The small-house model, implemented at Radcliff and Bowling Green, is designed to feel like a home or small community and emphasizes self-contained households with private suites and shared home-like common areas. This model has shorter hallways with rooms clustered around living and dining areas.

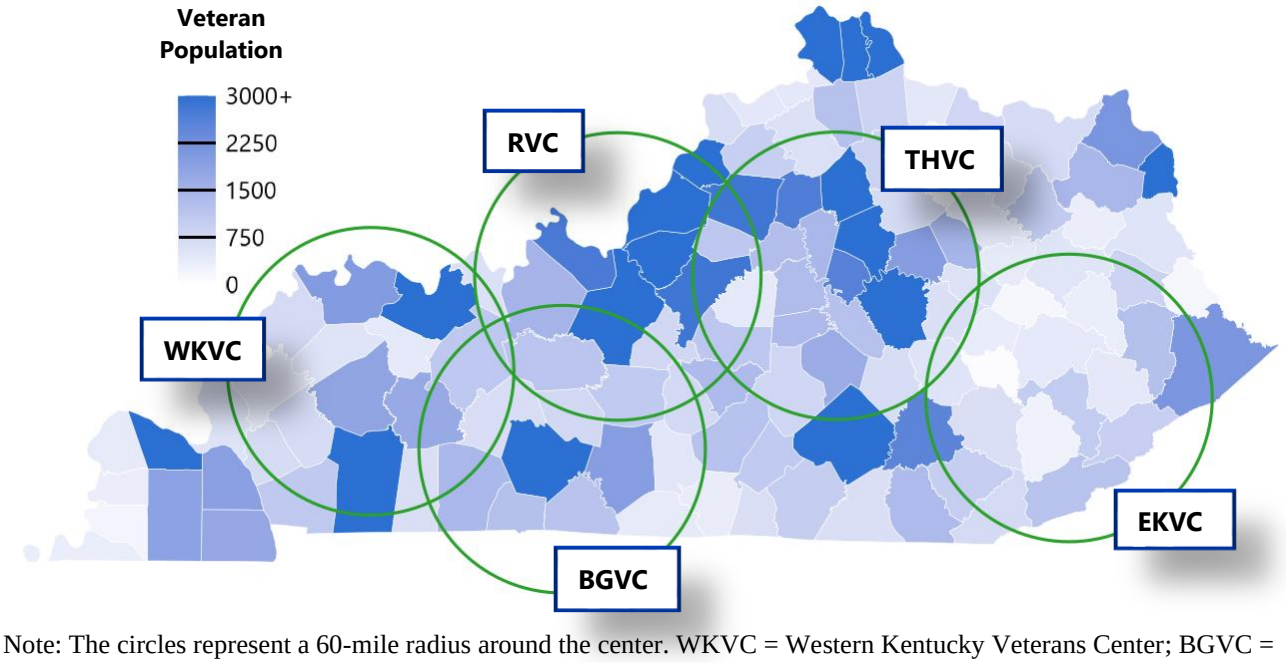
Secure behavioral units are available at three facilities. These provide controlled environments for residents with behavioral health conditions.

Secure units are included at THVC, EKVC, and WKVC, while RVC has a unit that is inactive until the completion of a capital project to repair an HVAC unit. These units provide controlled environments for residents with dementia, Alzheimer's disease, or other behavioral health conditions requiring close supervision and movement restriction.

The Radcliff and Bowling Green facilities were designed for single-occupancy rooms. The Thomson-Hood and Western Kentucky facilities have transitioned from double-occupancy to single-occupancy rooms. The Eastern facility remains a double-occupancy model.

Single-occupancy rooms are private rooms designed for one resident, offering greater privacy and infection control, while double-occupancy rooms house two residents and are more common in older institutional layouts. Kentucky's most recently constructed veterans' centers, RVC and BGVC, were designed for single-occupancy while THVC and WKVC have informally transitioned to single occupancy to varying degrees. EKVC, which is at near maximum capacity and staffing, maintains a double-occupancy model. Figure 2.A shows the location of each Kentucky veterans' center and its primary service area. The map also displays the density of the veteran population across the state in relation to veteran center coverage. Veteran population density and the geographic coverage provided by veterans' centers are discussed in more detail at the end of the chapter.

Figure 2.A
Regional Coverage Of Kentucky Veterans' Centers



Note: The circles represent a 60-mile radius around the center. WKVC = Western Kentucky Veterans Center; BGVC = Bowling Green Veterans Center; RVC = Radcliff Veterans Center; THVC = Thomson-Hood Veterans Center; and EKVC = Eastern Kentucky Veterans Center.
Source: LOIC staff compiled data on veteran population density and veteran facility coverage areas from information provided by the Kentucky Department of Veterans' Affairs and collected from the American Community Survey 5-year Estimates of 2023 from the U.S. Census Bureau.

Thomson-Hood Veterans Center

The Thomson-Hood Veterans Center has served veterans since 1991. It primarily serves veterans in central Kentucky.

Thomson-Hood Veterans Center was Kentucky's first veterans long-term care facility and has been serving Kentucky's veterans since 1991. The facility is located in Wilmore, Kentucky and sits near Asbury University. It primarily serves as the primary long-term care facility for veterans in central Kentucky, including the Lexington and Bluegrass regions.[59] Figure 2.B provides an exterior view of the facility and its grounds.

Figure 2.B
Thomson-Hood Veterans Center Campus

Source: Kentucky Department of Veterans' Affairs.

While THVC serves veterans from across the Commonwealth, it primarily draws admissions from Fayette, Jessamine, Madison, Scott, and Franklin counties. Its proximity to the Lexington VA Medical Center also makes it a referral hub for veterans requiring skilled nursing care or memory-care placement after acute VA hospital treatment.[60]

Thomson-Hood was constructed as a traditional institutional model, and resembles a hospital. It has undergone periodic modernization efforts.

THVC Facility Model. THVC was constructed in a traditional institutional-medical model, characterized by long corridors and centralized nursing stations which resemble a hospital. Although designed before the VA's 2011 transition to single-occupancy "small home" design standards, the facility has undergone periodic modernization projects and informally transitioned to single-occupancy rooms to improve resident privacy and comfort. Figure 2.C displays a residential corridor and nurses' station to provide insight into its medical-institutional modeled facilities.

Figure 2.C
Thomson-Hood Veterans Center
Medical-Institutional Facility Model

Source: Legislative Oversight committee staff visit on April 15, 2025.

The Thomson-Hood secured unit is the largest in Kentucky's veterans home system and is consistently near full occupancy.

THVC includes a secured behavioral health care unit, designed for residents with Alzheimer's disease and behavioral disorders which necessitate a controlled environment. The secured unit is the largest in Kentucky's veterans' home system and is consistently near full occupancy. KDVA reports that this is a reflection of the rising demand for behavioral and cognitive care among veterans.[61]

Thomson-Hood is Kentucky's largest veteran center. While it has a double-occupancy capacity of 285 beds, it currently operates with a single-occupancy capacity of 154 beds. If occupancy exceeds 154, it would have to return to the double-occupancy model.

THVC Room Type. In addition to being Kentucky's oldest facility, it is also the largest. Originally designed as a double-occupancy facility with a bed capacity of 285, it has operated single-occupancy rooms since COVID with a 154-bed capacity. The facility made the transition during the pandemic to impede the spread of COVID and due to the reduced occupancy created by the pandemic and has since been operating with one bed per room. The occupancy of the facility, as of March, 28, 2015, was 142 residents.[62] KDVA has reported that, if census increases past the 154 mark, it would have to consider returning to a double-occupancy model.[63] Figure 2.D shows a resident room at THVC which is currently used as a single-occupancy room but previously accommodated two residents.

Figure 2.D
Thomson-Hood Veterans Center
Resident Room Transitioned To Single Occupancy

Source: Legislative Oversight committee staff visit on April 15, 2025.

The Thomson-Hood layout increases staffing demands and results in diminished quality of life.

THVC Findings. LOIC staff found that THVC faces unique challenges related to its age, size, and design**.** The institutional layout increases staffing demands, limits modernization flexibility, and results in a diminished quality of life compared to other Kentucky veterans' centers such as RVC, WKVC, and BGVC. As discussed in later sections, modern long-term facilities are designed to feel like a resident's home with more space and privacy for individuals. If THVC were to revert back to double-occupancy rooms, each resident would have limited space and lose that privacy. As a result, veterans who live in the central Kentucky region and are unwilling to move may experience a worse standard of living than those in other regions.

KDVA has received $7 million in funding to modernize Thomson-Hood. The General Assembly should be updated on modernization efforts to ensure central Kentucky residents have a similar quality of life as those in other facilities.

KDVA has received $7 million in funding for a major interior and exterior renovation project to modernize THVC's infrastructure and resident spaces.[64] To ensure this funding is used appropriately and assists in central Kentucky veterans receiving a better quality of care, KDVA should update the General Assembly on the current capital projects that have been initiated to modernize THVC. This would allow the General Assembly to redirect KDVA if it is not satisfied with the efforts. If KDVA has not already consulted with the Division of Engineering and Contract Administration in the Finance Cabinet, it should consider contacting the office. As the facilities development experts, the division could provide insight to KDVA during planning.

Recommendation 2.2

Recommendation 2.2

The Kentucky Department of Veterans' Affairs should provide a report to the General Assembly on the current modernization needs associated with the Thomson-Hood Veterans Center. The report should include a review and update on the current capital projects underway and should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Staff also found that THVC's current capacity reporting is misleading and could complicate future veterans' center expansion and construction plans. THVC is licensed for 285 beds but is currently operating with an informal maximum capacity of 154 beds in order to maintain single-occupancy standards and quality of living for residents. KDVA reported that THVC is now approaching a census level (approximately 154 residents) at which a decision will be needed regarding whether to maintain single-occupancy rooms or transition back to double-occupancy.[65]

Chapter 3 contains additional discussion on how federal agencies are also transitioning to single-occupancy rooms. LOIC Staff and KDVA believe single-occupancy rooms are an important standard to maintain. As a result, staff recommend that KDVA continue to prioritize single-occupancy rooms at THVC once the census reaches 154 residents.

Recommendation 2.3

Recommendation 2.3

The Kentucky Department of Veterans' Affairs should continue to prioritize the use of single-occupancy rooms at Thomson-Hood Veterans Center as resident census levels increase.

Thomson-Hood's capacity is reported as 285 beds despite the facility only using 154 beds. This reporting decreases the occupancy rates for the facility.

The capacity of THVC is still being reported as 285 beds, so occupancy rates for the facility and the Kentucky veterans' center system as a whole are artificially suppressed. Currently, KDVA reports the facility's occupancy rate as approximately 49 percent, but once unused-but-certified beds are removed from total capacity numbers, this percentage increases to 91 percent occupancy. The currently reported occupancy, 49 percent, implies large amounts of excess capacity and suggests that the state could be admitting many more veterans at THVC. The functioning occupancy, 91 percent, indicates that the facility is near capacity under current VA and CMS single-occupancy standards.

The difference in use also affects Kentucky on a system level. With a limit of 818 beds that can receive federal per diems, unused beds reduce the state's total capacity.

This difference is not just an internal reporting problem as it also affects future veterans' center expansion and construction planning. Kentucky veterans' homes operate within two different capacity limiting systems. First, under federal regulation, the US Department of Veterans Affairs sets a maximum number of State Veterans Home beds in each state that are eligible for VA construction support and per diem funding. Kentucky's current VA-recognized cap is 818 total beds statewide. VA per diem payments are only available for beds that VA has certified toward that cap. When beds are certified despite having no plans for use, it essentially reduces Kentucky's total allocation of beds.

Recommendation 2.4

Recommendation 2.4

The Kentucky Department of Veterans' Affairs should decertify beds at Thomson-Hood Veterans Center that have been informally transitioned from double- to single-occupancy. The department should report on the progress of decertification to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military

Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Paul E. Patton Eastern Kentucky Veterans Center

The Eastern Kentucky Veterans Center opened in 2002 and primarily serves veterans in southeastern and eastern Kentucky.

The Paul E. Patton Eastern Kentucky Veterans Center is the Commonwealth's second oldest facility. The facility opened in 2002 and is located in Hazard, Kentucky. EKVC primarily serves veterans from southeastern and eastern Kentucky but accepts eligible Kentucky veterans statewide. Figure 2.E shows the exterior grounds and rural setting of EKVC.

Figure 2.E
Paul E. Patton Eastern Kentucky Veterans Center Campus

Source: Kentucky Department of Veterans' Affairs.

The Eastern Kentucky center is also designed in the medical-instructional model. The facility has a capacity of 120 beds and, as of May 2025, an occupancy of 96 residents.

EKVC Facility Model. Similar to THVC, EKVC was built before the federal VA and KDVA shift toward the small-homes model for long-term veteran's care. As a result, the facility is also designed in the medical-institutional model style. KDVA has tentative plans for modernization at EKVC, but the plans have not been formalized.[66] The facility has a maximum capacity of 120 beds and, as of May 2025, had an occupancy of 96 residents.[67] EKVC also includes a secure unit for residents with behavioral or mental health care needs. Figure 2.F provides images of the facilities interior.

Figure 2.F
Paul E. Patton Eastern Kentucky Veterans Center
Medical-Institutional Facility Model

Source: Legislative Oversight Committee staff visit on April 28, 2025.

The Eastern Kentucky center is the only facility to exclusively use double-occupancy rooms, which facility staff attributed to high census and the ability to staff for high occupancy.

EKVC Room Type. EKVC is the only Kentucky veterans' facility to exclusively use double-occupancy rooms. However, EKVC has not been included in KDVA's systemwide discussions regarding conversion to single-occupancy rooms. KDVA attributes this to EKVC's high census and ability to staff for high occupancy. KDVA reported to staff that EKVC has, since its opening in 2002, demonstrated enough need for 120 beds, as well as the ability to recruit and maintain sufficient staff to provide care for 120 veterans. Figure 2.G provides a photograph of one half of a double-occupancy room at EKVC.

Figure 2.G
Paul E. Patton Eastern Kentucky Veterans Center
Double-Occupancy Resident Room Model

Source: Legislative Oversight committee staff visit on April 28, 2025.

The Eastern Kentucky facility has historically had the highest occupancy rates and the fewest staffing shortages. As of May 2025, 95 percent of positions are staffed and 80 percent of beds are occupied.

EKVC Findings. KDVA and EKVC administration reported to staff that this facility has historically had the highest occupancy rates and fewest staffing shortages among Kentucky veterans' centers.[68] Staff review of Kentucky veterans' center occupancy rates and staffing data from 2015 to 2025 found this to be accurate. EKVC's occupancy rate has been consistently close to its certified capacity. As of May 2025, 94 percent of staffing positions at the facility are filled and 89 percent of positions have been consistently filled since 2018. Over this time span the turnover rate for the facility has only been 12 percent. The current occupancy rate is 80 percent.

Despite the Eastern Kentucky facility's staffing strengths, it should not be precluded from consideration of single-occupancy rooms or their benefits.

Despite EKVC's ability to sustain full staffing and consistently high occupancy, these operational strengths should not preclude consideration of single-occupancy conversion. High utilization and sufficient care provision alone do not reflect the broader benefits associated with single-occupancy design, such as improved infection control, privacy, and quality of life, nor the evolving expectations for modern long-term care environments. As KDVA continues to modernize its facilities, ensuring that EKVC is included in systemwide planning for single-occupancy transition remains an important step toward equitable facility standards and resident-centered care across all Kentucky veterans' centers.

Recommendation 2.5

Recommendation 2.5

The Kentucky Department of Veterans' Affairs should include the Eastern Kentucky Veterans Center in long-term systemwide planning and feasibility assessments related to transitioning to single-occupancy rooms.

Given the high occupancy rates for the Eastern Kentucky facility, an expansion or additional facility may be needed if the facility transitions to single-occupancy rooms.

Given the high occupancy rates for EKVC, it is likely that an expansion to the facility or construction of another facility in the eastern part of the state would be necessary to accommodate a transition to single-occupancy rooms. In 2017, KDVA commissioned Public Consulting Group to determine where to locate Kentucky's next state veterans' nursing home. The study used data on veteran demographics, population projections, and long-term care resources estimated through 2043 to identify areas of the state with the most unmet need for veteran's care.

A 2017 study estimated that the areas most in need of additional facilities were in south central, north central, and northern Kentucky. Since that study was completed, new facilities were established in south central and northern Kentucky. However, the study did not account for a transition to single-occupancy rooms.

The study determined that the three areas of Kentucky most in need of veteran's long term care facilities were south central Kentucky (Adair, Allen, Barren, Warren, and Pulaski counties), north central (Jefferson, Hardin, Nelson counties), and northern Kentucky (Boone, Kenton, and Campbell counties). Northeastern and southeastern Kentucky were ranked 5th and 7th, respectively. Since that study was completed, new facilities have been established in both south central Kentucky (Bowling Green Veterans Center) and northern Kentucky (Radcliff Veterans Center), satisfying two of the highest-priority regions identified in 2017. However, the 2017 feasibility analysis did not account for the systemwide transition from double- to single-occupancy rooms, which should be a priority for KDVA.

The 2022-2024 budget established that no new veterans' nursing home beds be allocated until all existing homes reach 80 percent capacity.

Additionally, House Bill 352 (2020 Acts Chapter 92) established a policy directing that, aside from the Bowling Green project, no new state veterans' nursing home beds be allocated until all existing homes reach at least 80 percent occupancy.[69] Once that occupancy threshold is achieved, the General Assembly expressed its intent that any new beds awarded, either through the US Department of Veterans Affairs or reallocated by KDVA, be dedicated to establishing a facility in Magoffin County.

Formally transitioning to single-occupancy beds will bring the state occupancy rate to near 80 percent. KDVA should conduct a new feasibility study to reassess statewide demand under single-occupancy conditions and to consider the effect of newer facilities.

The transition to single-occupancy beds, and the decertification of double-occupancy beds, will bring Kentucky's occupancy rate to near 80 percent and opens the possibility of developing a new facility. Given the continuing high occupancy at EKVC and the likelihood that statewide occupancy could exceed 80 percent in the near future, KDVA should conduct a new veterans center location feasibility study to reassess statewide demand under single-occupancy conditions and to determine whether the eastern Kentucky region, including Magoffin County, should be prioritized for the next state veterans' center.

Recommendation 2.6

Recommendation 2.6

Prior to new construction or facility expansion decisions, the Kentucky Department of Veterans' Affairs should conduct a new statewide veterans' center location feasibility study to evaluate the need for future facility construction or expansion. The study should account for the opening of the two most recent veterans' centers, which addressed the two previous highest areas of need identified in the state; and account for the potential impact of transitioning all state veterans' centers to single-occupancy room configurations.

Joseph "Eddie" Ballard Western Kentucky Veterans Center

The Western Kentucky Veterans Center was opened in 2002 but three community living centers were added in 2013. It primarily serves residents from western Kentucky.

WKVC is located in Hanson, Kentucky and was opened in 2002 as one central facility. In 2013, three additional smaller community living centers were built as separate cottage-residential style buildings behind the main facility. Like Kentucky's other veterans' centers, WKVC serves veterans from across the commonwealth but draws most of its residents from western Kentucky, reflecting its proximity to regional population centers such as Madisonville, Owensboro, and Paducah. Figure 2.H provides an aerial map of the facilities and campus.

Figure 2.H
Joseph "Eddie" Ballard Western Kentucky Veterans Center Campus

Source: Kentucky Department of Veterans' Affairs.

The Western Kentucky center is a hybrid facility. Its central facility is based on the medical-institutional philosophy while the newer facilities are designed as small residential communities. As of May 2025, the center has a capacity of 156 beds and 83 residents.

WKVC Facility Model. WKVC is a hybrid of two facility models. The central facility, built in 2002, follows a medical-institutional design philosophy while the three smaller facilities, built in 2013, are designed as small residential communities in the cottage-residential model. Combined, these facilities have a certified capacity of 156 beds and an occupancy of 83 residents as of May 2025. The facility includes a secured unit for the care of patients with behavioral, memory, or mental health care needs.

Facility staff reported persistent staffing shortages, particularly among nursing and direct-care positions. This resulted in one full unit being temporarily closed, except when a quarantine area is needed.

In recent years, WKVC has faced persistent staffing shortages, particularly among nursing and direct-care positions. These challenges have led to reduced occupancy levels and higher reliance on temporary or contract staff compared to Kentucky's other veterans' centers. KDVA reported that the primary causes of these shortages are competitive wage pressures in the region's healthcare labor market, challenges attracting licensed nurses to rural areas, and insufficient locality premiums.[70] WKVC administrators report that one full unit of the facility remains

closed due to staffing and budget constraints. The unit was repurposed during the pandemic as a quarantine area and continues to serve in this role.[71]

Many of the Western Kentucky Center units transitioned to single-occupancy rooms because of staffing and budget concerns. It was maintained due to a desire to improve quality of life for residents. Current single-occupancy capacity is 112 beds, as opposed to its 156 certified beds.

WKVC Room Type. As a result of staffing and budget challenges, many of the facility's units have been transitioned from double-occupancy rooms to single-occupancy rooms. The facility began this transition during the COVID pandemic in order to adhere to social distancing standards. The transition to single-occupancy rooms has since been maintained due to a combination of staffing shortages and a desire to improve the quality of living for residents.[72] As a result, the current single-occupancy capacity of the facility is 112 beds, as opposed to its 156 certified capacity. Figure 2.I provides photographs of two residential rooms at WKVC highlighting the difference between single and double occupancy. The image on the left displays a room certified for double occupancy while the image on the right shows a similar room designed for single occupancy.

Figure 2.I
Joseph "Eddie" Ballard Western Kentucky Veterans Center
Double- And Single-Occupancy Resident Room Model

Source: Kentucky Department of Veterans' Affairs.

The Western Kentucky Veterans Center typically has filled 70 percent of staffing positions, which lags behind two of the three other facilities.

WKVC Findings. KDVA and WKVC administrators report that WKVC is the Kentucky veterans center most impacted by staffing challenges historically. The facility's staffing data supports this but indicates that the facility has recently significantly improved its staffing. For FY 2025, WKVC maintained 91 percent of staffing positions filled which is on par or higher than Kentucky's other facilities.[73] However, this is a recent improvement as the facility averaged approximately 70 percent staffing filled from 2018 – 2024. This has consistently lagged behind THVC and EKVC.[e]

The center's staffing challenges began in 2012. In 2023, the facility was approved for special entry rates and increased locality premiums, which increased the number of staff recruited.

KDVA reported that staffing challenges began in 2012 with the addition of 36 beds in the small-house and cottage section of the campus. In June 2023, KDVA received assistance through the approval of special entry rates for nursing staff and increased locality premiums for regional staffing. Staffing numbers increased from 126 positions to 148 positions in 2025 as a result.[74]

While KDVA reported concerns filling staffing positions at the facility, WKVC administrators reported that their primary constraint is not filling existing positions but instead being limited by OKVC's personnel cap, which they wish to see increased.[75] OKVC has stated that, given WKVC's historical census which peaked at 115 residents and the possibility of a facility shift to single-occupancy, a staffing cap increase may not be necessary.[76]

KDVA views the Western Kentucky Veterans Center as a strong candidate for a full transition to single-occupancy rooms because staffing for double-occupancy rooms is difficult.

KDVA reported that despite increases in funding and relief in the form of locality premiums and special entry rates, they believe that market conditions may preclude staffing for the full 156 certified bed capacity at WKVC. As a result, KDVA views the facility as a strong candidate for a full transition to single-occupancy rooms. At double-occupancy (156 bed capacity), the facility's occupancy rate is much lower (53 percent).

While conversion to single-occupancy rooms should remain a goal, persistent staffing challenges should be addressed.

Although conversion to single-occupancy rooms should remain a long-term goal, persistent staffing challenges should also be addressed. Under 101 KAR 2:034 and related Personnel Cabinet compensation policies, agencies may request both a locality premium (for a specific job class and county) and a special entrance rate (to make entry salaries more competitive statewide).

[e] RVC's staffing levels have remained below WKVC averages since its opening. The facility's capacity and occupancy have, however, been heavily influenced by COVID-19 and ongoing capital projects. The facility has averaged only 54 percent of full-time positions filled since 2018, though these external factors make definitive conclusions difficult.

It is unclear whether historic recruitment and retention difficulties at WKVC have been resolved with recent improvements. As a result, KDVA should work with the Personnel Cabinet to determine whether continued or increased locality premiums and special entry rates are justified, and whether higher personnel limits are warranted.

Recommendation 2.7

Recommendation 2.7

The Kentucky Department of Veterans' Affairs should work with the Kentucky Personnel Cabinet to evaluate if increased locality premiums and special entry rates are warranted, and whether increased personnel limits are justified for positions at the Western Kentucky Veterans Center.

Recommendation 2.8

Recommendation 2.8

The Kentucky Department of Veterans' Affairs should decertify beds at Western Kentucky Veterans Center that have been informally transitioned from double- to single-occupancy. The department should report on the progress of decertification to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Carl M. Brashear Radcliff Veterans Center

The Carol M. Brashear Radcliff Veterans Center was opened in 2017 and serves veterans primarily from central and western Kentucky. It uses a residential model, with four small-house-style neighborhoods.

The Carl M. Brashear Radcliff Veterans Center opened in 2017, is Kentucky's newest operational state veterans nursing facility. Located in Hardin County, RVC was designed to serve veterans primarily from central and western Kentucky. The facility has a focus on providing a modern, residential environment rather than an institutional one. The facility is organized into four small-house–style neighborhoods, each designed to promote autonomy and community among residents.[77] Figure 2.J shows an aerial view of the RVC campus and facilities.

Figure 2.J
Carl M. Brashear Radcliff Veterans Center Campus

Source: Kentucky Department of Veterans' Affairs.

The Radcliff facility was built in 2017 with 120 single-occupancy rooms, but has been operating with 60 beds since a major HVAC failure in 2022. Its occupancy as of May 2025 is 57 residents.

RVC Facility Model. RVC is designed with a small-homes model which differs considerably from the institutional-medical models of THVC and EKVC. RVC was built in 2017 with 120 single-occupancy rooms to align with contemporary long-term care standards emphasizing privacy, infection control, and resident quality of life. However, the facility has been operating at reduced capacity since 2022 due to a major HVAC system failure and subsequent renovation project, which temporarily closed half of its available beds. Current capacity, as of May 2025, is 60 beds and current occupancy is 57 residents.[78]

As of May 2025, the replacement of the HVAC system in the first half of the facility has an estimated final completion date of March 2026. The procurement for replacing the HVAC system in the second half of the facility has not yet been completed but KDVA expects it to be approved by March 2026. KDVA reports that they expect that Phase 2 will require slightly more time than Phase 1to complete. Current estimates are that this phase will be complete in the second quarter of 2027. Upon the completion of Phase 2, there will be a period of time required to admit veterans to bring the facility up to full capacity. Full capacity is not expected until 2028. Figure 2.K provides a photograph of a common room at RVC.

Figure 2.K
Carl M. Brashear Radcliff Veterans Center
Small-Homes Model

Source: Legislative Oversight Committee staff visit on April 30, 2025.

The Radcliff Veterans Center's beds are housed in four clusters of 10-bed "houses." The houses share a kitchen, dining area, and living room but residents have individual bathrooms.

RVC Room Type. Each of RVC's 120 licensed beds is housed within one of four residential neighborhoods, each containing three 10-bed "houses." These smaller clusters create a decentralized care model that aligns with the small-house design philosophy increasingly adopted in long-term care. They include a shared kitchen, dining area, and living room. All rooms are single occupancy with individual bathrooms. Figure 2.L shows one of RVC's single-occupancy resident rooms.

Figure 2.L
Carl M. Brashear Radcliff Veterans Center
Single-Occupancy Resident Room Model

Source: Legislative Oversight Committee staff visit on April 30, 2025.

The Radcliff facility is Kentucky's most modern veteran center, with single-occupancy rooms arranged in home-like environments.

RVC Findings. RVC is the state's most modern operating veterans long-term care facility. It features a modern design and provides high-acuity long-term care, with all single-occupancy rooms arranged in household-style units that promote a more home-like environment.[79] The facility is a model for other facilities in the state to follow, and is a major influence on, the soon to be opened, BGVC.

The Radcliff Veterans Center has had occupancy challenges. COVID drove occupancy to approximately 30 percent and a HVAC system failure decreased maximum capacity by 50 percent.

Despite the facility's high quality and modern design, it has had ongoing occupancy challenges. The Radcliff Veterans Center began admitting residents in May 2017. Although it takes time for new facilities to reach full occupancy, Radcliff climbed to over 50 percent by 2019 before the COVID-19 pandemic caused a sharp

decline in census, with occupancy falling to around 30 percent. Since then, the facility has remained below 50 percent occupancy due in large part to the malfunction and ongoing replacement of its HVAC system.[80]

Repairs to the HVAC system have an estimated cost of at least $25 million.

RVC HVAC Capital Project. The repairs and replacement project related to RVC's HVAC system have limited the capacity of the facility and potentially denied access to veterans. It is also forecasted to cost the state at least $25 million, $9 million of which has already been awarded.[81] $16 million has been requested for the 2026-28 biennium.[82]

Legal requirements for the HVAC procurement were outside the scope of this study but there may be a benefit in having a more specialized office determine if there is recourse for the poor performance of the system.

This system was a Trane HVAC co-branded with Samsung Electronics.[83] A review of legal requirements for the HVAC procurement was outside the scope of the study, but there may be a benefit to having a more specialized office review the circumstances to determine if there is recourse for the state as RVC had numerous issues with the HVAC system during its warranty period.

The HVAC system was installed in 2017 but repeated warranty replacements occurred by 2020. By 2022, a complete system replacement was necessary.

RVC began experiencing issues with the system within 2 years of its installation. The HVAC system was installed during the facility's opening in 2017 and, by 2020, ongoing issues had already led to repeated manufacturer warranty replacements. By 2022, persistent failures led to the assessment that a complete system redesign and replacement was necessary.[84]

Phase 1 of the HVAC replacement is expected to be completed by March 2026. At that time, all residents will be moved to the renovated wing and the previously used wing will be updated.

Phase 1 of the project is expected to be completed by March 2026. At that time, all residents will be relocated from their current wing to the newly renovated wing with the updated HVAC system. Phase 2 will begin immediately thereafter and will address the HVAC system in the remaining half of the facility. Completion of Phase 2 is estimated for mid-2027. The admissions process takes time, so full recovery from the HVAC project, and therefore full occupancy at the facility, is not anticipated until early 2028.[85] An additional concern is that the HVAC system was problematic while still under warranty, yet a full replacement of the system was not pursued until after the warranty expired. Complicating matters, in early 2018, Trane ended its partnership with Samsung which had previous provided all warranty support.[86]

A nursing home in Glasgow, Kentucky, has a similar system from a different manufacturer that was installed in 2011. As of June 25, 2025, the system still functions.

Staff also identified a nursing home in Glasgow, Kentucky, which installed a similar system from a different manufacturer around 2011. The system was still functioning as of June 25, 2025.[87] Moreover, KDVA reported to staff that HVAC systems in other

facilities have performed well under warranty, although they have necessitated repairs and renovations over time.[88]

Given that the HVAC system was problematic while still under warranty, yet a full replacement of the system was not pursued until after the warranty expired and the unique circumstances surrounding the manufacturer ending its partnership with its warranty provider, it is possible that the procurement process for the system did not properly vet the vendor or did not properly seek a replacement while still covered by a warranty.

Moreover, given that similar systems have worked for longer than the Radcliff HVAC system and systems at other Kentucky veterans' centers have not required capital project replacement this soon after installation, there is potential that the Radcliff system was deficient in some way which might make some recourse available to the state.

Given that KRS 6.935 states that the Attorney General, the Auditor of Public Accounts, and heads of state agencies shall assist the Legislative Oversight and Investigations Committee in whatever manner the co-chairs deem helpful, this report recommends that the Attorney General's office should review the legal requirements of the contract to determine if the HVAC manufacturer did not sufficiently provide services and review precedent for recourse when products are deficient. Also, staff recommend that the procurement process for the original HVAC system be reviewed by the Auditor's Office.

Matter For Legislative Consideration 2.B

Matter For Legislative Consideration 2.B

The General Assembly may wish to refer the matter of the procurement, installation, repair, warranty coverage, and replacement of the HVAC system installed at the Radcliff Veterans Center to the Office of the Auditor of Public Accounts and the Office of the Attorney General for review.

Robert E. Spiller Bowling Green Veterans Center

The Bowling Green Veteran Center is the first new center since the Radcliff facility was built. It is expected to open in the second quarter of 2026 and will have a capacity of 60 single-occupancy beds.

BGVC is Kentucky's fifth state veterans' nursing facility and the first new construction since the opening of the Radcliff Veterans Center in 2017.[89] The facility was built in response to KDVA's 2017 location feasibility study which identified Kentucky's south-central region as the highest priority area for veterans' care expansion.[90] BGVC is located in Bowling Green, Kentucky (Warren County) and has a capacity of 60 beds. Construction of BGVC was funded jointly by state appropriations and a federal

grant from the US Department of Veterans Affairs State Home Construction Grant Program, which covers up to 65 percent of eligible costs. The General Assembly approved the project in the 2020–22 Executive Branch budget, and construction began in 2022. The facility is expected to open in April of 2026.[91] Figure 2.M shows the campus and facility layout of BGVC.

Figure 2.M
Robert E. Spiller Bowling Green Veterans Center Campus

Note: The picture is an artist's rendering of the campus and facility layout of the Bowling Green Veterans Center.
Source: Kentucky Department of Veterans' Affairs.

The Bowling Green Center is designed around a small-house model. Each small house has shared living spaces.

BGVC Facility Model. BGVC is designed according to a small-house model, which reflects a growing national trend in long-term care emphasizing quality of life, privacy, and resident-centered care. Each small house functions as a self-contained home with a limited number of residents, private bedrooms and bathrooms, and shared living spaces such as a kitchen, dining area, and living room. The facility's architectural style and interior design further reinforce its residential character, as the facility bears little resemblance to medical-intuitional style facilities like THVC and EKVC. Figure 2.N shows a photograph of a BGVC common room that was under construction at the time. The room serves as a community hub for resident rooms that are clustered around it.

Figure 2.N
Robert E. Spiller Bowling Green Veterans Center
Small-Homes Model

Source: Legislative Oversight Committee staff visit on April 17, 2025.

All resident homes at the Bowling Green Center are single-occupancy with private bathrooms. Each room opens into a shared household living space.

BGVC Room Type. All resident rooms at the Bowling Green Veterans Center are designed as single-occupancy accommodations with private bathrooms, consistent with the facility's small-house care model. The rooms are designed to meet or exceed both the VA and CMS standards for skilled nursing facilities. Each room opens directly into a small shared household living space rather than an institutional hallway, contributing to the facility's residential character.[92] Figure 2.O shows a residential room at BGVC.

Figure 2.O
Robert E. Spiller Bowling Green Veterans Center
Single-Occupancy Resident Room Model

Source: Legislative Oversight Committee staff visit on April 17, 2025.

BGVC Findings. The Bowling Green Veterans Center, scheduled to open in 2026, will be the newest addition to Kentucky's system of state veterans' homes. Although the facility is not yet operational, site visits indicated that it is well-designed and constructed to a high standard. The layout and resident areas reflect a modern approach to long-term care, emphasizing accessibility, privacy, and comfort.

The Bowling Green Center was originally scoped for 120 residents, providing capacity for future expansion if warranted.

The facility was originally scoped and certified for 120 residents, providing capacity for future expansion if warranted.[93] BGVC will serve South Central Kentucky, a region identified by the 2017 Public Consulting Group feasibility study as having the greatest unmet need for veterans' long-term care services. The design focus on single-occupancy rooms is a model the Kentucky veterans' center system is looking to follow statewide.

Chapter 3

Are Capacity And Occupancy Impacting Revenue And Access To Care?

This chapter examines whether current capacity and occupancy affect system revenue or limit veterans' access to care, focusing on how modernization, staffing, and facility design shape systemwide capacity.

This chapter examines two key policy questions: whether current occupancy and capacity levels affect the revenue of the veterans' center system, and whether they limit veterans' access to care. These issues are examined at the system level, focusing on how modernization, staffing, and facility design influence capacity and occupancy across Kentucky veterans' centers. It begins with Kentucky's ongoing transition to single-occupancy rooms, a modernization effort supported by the Kentucky Department of Veterans' Affairs, the US Department of Veterans Affairs, and the Centers for Medicare and Medicaid Services which enhances resident quality of life but also changes how capacity and occupancy are defined and measured.[94]

The remainder of the chapter clarifies statewide capacity and occupancy rates in light of this transition and other factors such as ongoing capital projects. It then evaluates whether operating below full capacity results in lost revenue for the state and estimates the financial cost of achieving higher occupancy levels. Finally, it reviews overall federal and state funding for Kentucky veterans' centers and examines where capacity remains available within the system.

Statewide Transition To Single-Occupancy Rooms

Modern long-term care design increasingly favors single-occupancy rooms because they improve quality of life, dignity, infection control, and individualized care.

Modern long-term care design increasingly emphasizes single-occupancy rooms as a means to enhance resident quality of life, dignity, and infection control while reducing behavioral disturbances associated with shared living arrangements. Single-occupancy models also allow for more individualized care and improved quality-of-life outcomes consistent with current federal and industry standards. Recognizing these benefits, KDVA has reported interest in transitioning Kentucky facilities in this direction as renovations, staffing, and census levels allow.[95]

The Kentucky Department of Veterans' Affairs has developed several proposals to transition the Thomson-Hood and West Kentucky centers to single-occupancy rooms.

KDVA. According to KDVA, the agency has developed multiple models and proposals dating back to 2017 to transition the Thomson-Hood Veterans Center and the Western Kentucky Veterans Center to single-occupancy private rooms. KDVA cited resident quality of life, infection control considerations, staffing challenges, and quality-of-care as the primary factors driving the discussions.[96]

Staff were informed that managing a large facility such as THVC and its 285 beds is increasingly difficult under current healthcare conditions, and that both staffing shortages and declining census trends at WKVC support re-evaluating existing bed configurations and realistic operating capacities.[97] The Office of Kentucky Veterans' Centers also noted that the VA has not funded or authorized new state veterans' home construction with shared rooms since 2011, requiring all newly funded federal facilities to be designed with private suites and private bathrooms. Under those standards, Kentucky's older facilities would have been constructed with private rooms and at smaller scale if constructed today.[98]

Although KDVA has tabled broader discussions on statewide conversion to single-occupancy rooms, the Radcliff center and the future Bowling Green Center are designed with private suites, and THVC and WKVC have operated with single-occupancy rooms since 2020.

KDVA's internal discussions on statewide conversion to single-occupancy rooms is currently tabled pending broader consideration of occupancy levels and access for veterans. However, KDVA reported that the Radcliff Veterans Center and the soon to open Bowling Green Veterans Center are already designed exclusively with private suites. The Eastern Kentucky Veterans Center has not been included in these discussions due to its consistently high occupancy, which would make conversion to single-occupancy complex.[99] OKVC noted that its preference is that each facility's configuration be evaluated individually based on local service area needs and operational realities, rather than through a uniform statewide approach.[100]

THVC and WKVC transitioned to single-occupancy room use in 2020 during the height of the COVID-19 pandemic to improve infection control and safeguard residents. This transition was made possible by the drop in occupancy that accompanied the pandemic. Although veteran admissions have continued since that time, overall census levels have not required a return to double-occupancy room configurations. KDVA reported that THVC is now approaching a census level, approximately 154 residents, at which a decision will be needed regarding whether to maintain single-occupancy rooms.[101]

The VA treats single-occupancy rooms as a best practice and now funds only single-occupancy designs for federal facilities.

US Department Of Veterans Affairs. The VA encourages and, treats as best practice, that all newly constructed or renovated state veterans' homes funded through the State Home Construction Grant Program be designed with private bedrooms and private bathrooms. Moreover, KDVA reported that the VA is no longer funding or authorizing new federal construction to be anything other than single-occupancy.[102] The VA's preference for single-occupancy rooms can be seen in the *VA Design Guide for State Veterans Homes* and subsequent updates under 38 CFR pt. 59. This design policy reflects an emphasis on infection control, resident privacy, and the creation of a home-like environment consistent with modern long-term care standards. Additionally, the VA no longer allows multi-occupancy rooms for newly constructed VA operated federal facilities.[103]

CMS endorses private-room design to strengthen infection control and resident quality of life, and since 2016 it no longer certifies facilities with more than two residents per room.

Centers For Medicare And Medicaid Services. CMS also endorses private-room configurations as best practice for infection prevention and resident quality of life. Federal regulations require that nursing facilities provide accommodations consistent with resident rights to privacy and comfort. CMS has lowered its design expectations for room occupancy and, as of 2016, will no longer certify facilities that have designs with more than two residents per room. Previously, this threshold was four residents per room.[104] CMS memoranda issued during and after the COVID-19 pandemic further encouraged states and providers to incorporate single-occupancy design in renovations and new construction to reduce airborne and contact-based transmission of infectious disease.[105]

NASVH supports single-occupancy models with private rooms. Several states, including Michigan, Tennessee, and Ohio, are already adopting these designs or converting existing facilities to single-occupancy layouts.

National Association Of State Veterans Homes. The National Association of State Veterans Homes (NASVH) strongly supports the transitioning from double to single-occupancy rooms.[106] Additionally, in testimony to congress, NASVH has advocated for the "small house" model for state veterans' homes where veterans are housed in smaller groups, with their own rooms, dedicated kitchens and services.[107]

Other States. Several states have already implemented or are transitioning toward full single-occupancy configurations. Michigan reorganized its veterans' home system beginning in 2016 to develop smaller neighborhood-style facilities composed of private suites.[108] Tennessee has adopted a similar small-house standard for new state veterans' homes.[109] The superintendent of the Office of Ohio Veterans Homes reported that Ohio is currently redesigning their facilities in Sandusky and Georgetown to convert to a single-occupancy room model.[110]

Given the demonstrated benefits of single-occupancy rooms for veterans' quality of life, KDVA should conduct a feasibility study to evaluate maintaining single-occupancy rooms at THVC and WKVC and transitioning EKVC to a single-occupancy model.

Recommendation 3.1

Recommendation 3.1

The Kentucky Department of Veterans' Affairs should evaluate transitioning all Kentucky veterans' centers to single-occupancy rooms statewide and report their findings and the status of current facilities to the General Assembly. In addition to evaluating and maintaining single-occupancy rooms at the Thomson-Hood Veterans Center and the Western Kentucky Veterans Center, the report should investigate transitioning Eastern Kentucky Veterans Center to single-occupancy rooms. The report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Transitioning to single-occupancy rooms reduces functional capacity relative to certified capacity, making it essential to distinguish between the two when interpreting statewide capacity and occupancy rates.

Aligning facilities with single-occupancy room standards changes how much of Kentucky's certified capacity is functionally available. Drawing a clear distinction between certified and functional capacity is essential to accurately interpreting statewide capacity, which is lower under this model, and occupancy rate, which is generally higher. Additionally, the ongoing capital projects, renovations, and modernization efforts, like the HVAC replacement at RVC, have the potential to further misconstrue statewide capacity and occupancy rates unless reported accurately. The following section presents adjusted facility capacity and occupancy rates in light of these factors.

Comparing Certified And Functional Capacity

Certified capacity is the maximum number of VA and state-approved beds a facility is authorized to operate and is the figure KDVA typically reports. Functional capacity reflects the beds actually available for resident use.

For the purpose of this report, certified capacity refers to the maximum number of beds formally approved and recognized by the VA and the Kentucky Office of Inspector General for reimbursement and regulatory purposes. It represents the maximum number of beds a facility is authorized to operate and is typically the number reported by KDVA when reporting veteran center capacity and occupancy.

Functional capacity, by contrast, reflects the number of beds that are actually available for resident use when accounting for factors such as ongoing construction and rooms informally or temporarily

removed from service, such as the case of double-occupancy rooms transitioned to single-occupancy rooms. Certified capacity may remain constant even as functional capacity declines, resulting in lower reported occupancy rates and inaccurate depictions of maximum capacity.

Single-Occupancy Impact On Functional Capacity

Kentucky's four veterans' centers have a certified capacity of 681 beds but functional capacity is lower due to shifts to single-occupancy rooms. Statewide, this reduces functional capacity to 506 beds.

Kentucky is certified by the federal VA to operate long-term veterans' care facilities up to a maximum of 818 beds. The VA will not provide funding for any beds beyond this limit.[111] As of this report, Kentucky has four veterans' long-term care facilities with a certified capacity of 681 beds, with one soon to open in BGVC. However, Kentucky's actual functional capacity is less than this certified total.

THVC is certified for 285 beds but has unofficially transitioned its double-occupancy rooms to single-occupancy rooms, reducing functional capacity to 154 beds. Likewise, WKVC transitioned to single-occupancy rooms as a result of both staffing shortages and a recognition of quality-of-life improvements. While WKVC is certified for 156 beds, it can only accommodate 112 beds in a single-occupancy configuration. RVC is already designed with single-occupancy rooms, and EKVC has yet to transition any of its double-occupancy rooms. Accounting for these transitioned rooms lowers the functional capacity of the statewide veteran's care system from 681 beds to 506 beds.

RVC's ongoing HVAC replacement limits it to half of its 120-bed capacity, further reducing statewide functional capacity from 506 to 446 beds.

Capital Project Impact On Functional Capacity. RVC is currently limited to half of its 120-bed capacity due to the previously discussed HVAC replacement project. Accounting for these adjustments further decreases the functional capacity of the statewide system from 506 to 446 beds.

As of May 2025, Kentucky veterans' centers housed 378 residents, producing a functional occupancy rate of 85 percent.

Kentucky Veterans' Centers Functional Occupancy Rate. As of May 2025, the occupancy across all Kentucky veterans' centers is 378 residents. When measured against the systems statewide functional capacity of 446 beds, this equates to an occupancy rate of approximately 85 percent as opposed to the 56 percent occupancy rate typically reported by KDVA.

To put these numbers in context, data from the VA shows that the national average occupancy rate for state veterans' long-term care facilities was 63 percent in December 2024.[112] Occupancy rates among states varied, from approximately 30 to 90 percent, but the underlying causes of these differences cannot be determined

without a consistent understanding of each state's admission policies, capacity definitions, and reporting methods. For instance, a 90 percent occupancy rate may reflect efficient operations when waiting lists are short but could also signal unmet demand if waiting lists are long.

The national average occupancy for state veterans' homes was 63 percent in December 2024, though rates vary widely and are difficult to interpret without consistent definitions of capacity, admissions practices, and reporting methods.

Table 3.1 shows the functional occupancy rates for each of Kentucky's operating veterans' centers when accounting for the decertification of unused double-occupancy beds and beds unavailable due to construction projects. The table shows that 175 unused double-occupancy beds are currently counting against Kentucky's certified bed total and should be decertified. When combined with the 60 unavailable beds at RVC this results in relatively high occupancy rates across the veterans' center system. THVC and RVC both have occupancy rates above 90 percent, while WKVC and EKVC have rates above 75 percent.

Table 3.1
Kentucky Veterans' Centers
Certified And Functional Occupancy Rates
As Of May 2025

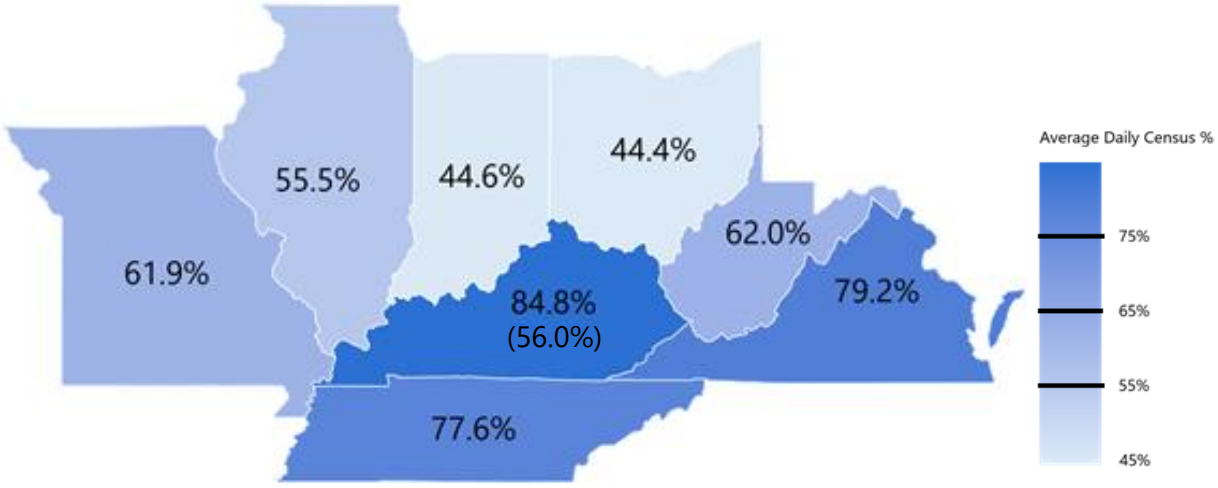
Veteran Center	Occupancy	Certified Capacity	Certified Occupancy Rate	Double-Occupancy Beds	N/A Capacity	Functional Capacity	Functional Occupancy Rate
Thomson-Hood	142	285	50%	131	0	154	92%
Eastern KY	96	120	80	0	0	120	80
Western KY	83	156	53	44	0	112	74
Radcliff	57	120	48	0	60	60	95
Total	378	681	56%	175	60	446	85%

Note: "N/A Capacity" refers to beds not available due to infrastructure repairs.
Source: LOIC staff compiled data from KDVA data requests which included information on occupancy and capacity. Provided to LOIC staff Aug 18, 2025.

Kentucky's 85 percent functional occupancy rate is high compared to its regional neighbors.

Calculating occupancy under these conditions puts Kentucky veterans' centers occupancy rate in different context when compared to its neighboring states. Figure 3.A shows that Kentucky's 85 percent average functional occupancy rate is higher than any state in the region, aside from Tennessee's 90 percent rate, while its 56 percent average certified occupancy rate is one of the lowest in the region.

Figure 3.A
Regional Comparison Of Veterans' Centers
Average Occupancy Rates
2024



Note: 84.8 percent occupancy rate for Kentucky reflect functional capacity while the 56 percent occupancy rate reflects certified capacity.
Source: Staff analysis of US Department of Veterans Affairs, Freedom of Information Act request for veteran center capacity and census, email from Johan Englen, FOIA officer, to Shane Stevens, Aug. 29, 2025.

The gap between certified and functional occupancy rates creates misleadingly low statewide occupancy figures and has policy implications for Kentucky's 80 percent authorization threshold and the VA's 90 percent bed-hold requirement.

Policy And Reporting Implications Of Certified Versus Functional Capacity. The gap between Kentucky's certified occupancy rate and its functional occupancy rate has policy consequences. When occupancy is calculated against certified beds that are no longer practically available because of single-occupancy conversions or capital projects, the statewide rate appears artificially low. When the same census is measured against functional capacity, the occupancy rate is materially higher.

This distinction is important for accurately communicating system performance to the General Assembly, but it also affects eligibility under two separate thresholds: the state budget policy that no additional veterans' nursing home beds will be authorized until existing homes reach 80 percent occupancy, and the federal requirement that facilities operate at or near 90 percent occupancy to qualify for VA bed-hold per diem reimbursement.[113] Once double-occupancy beds have been decertified and capital projects are completed, certified and functional occupancy rates should converge. However, reporting both figures will remain important to reflect any future capital projects, renovations, or staffing fluctuations that may temporarily affect capacity.

Reporting both certified and functional capacity would give policymakers and stakeholders a clearer view of true bed availability and system performance.

To ensure occupancy data accurately reflects the system's true operating conditions, KDVA should report certified and functional capacity, and their corresponding occupancy rates in future legislative reporting, stakeholder communications, and budget submissions. Presenting both measures would provide policymakers with a clearer understanding of how facility renovations, modernization projects, single-occupancy room transitions, and other factors affect true bed availability. It would also provide applicants and other stakeholders with a more accurate context for assessing the true capacity and utilization of Kentucky veterans' centers.

Recommendation 3.2

Recommendation 3.2

In future legislative reporting, stakeholder communications, and budget submissions, the Kentucky Department of Veterans' Affairs should adopt the policy of reporting functional occupancy rates and functional capacity in addition to total certified occupancy rates and certified capacity.

The following section examines whether operating at higher occupancy levels would increase revenue. Specifically, it assesses whether operating below 90 percent occupancy results in significant lost revenue from VA bed-hold per diem reimbursements.

Does Operating Veterans' Centers Below 90 Percent Occupancy Result In Lost Revenue For Kentucky?

Although payor mix influences revenue because reimbursement rates vary across VA per diem, Medicaid, Medicare, and private pay, none of Kentucky veterans' centers covers their roughly $721 per-patient-day cost under any combination of funding sources.

KDVA officials reported that financial outcomes of veteran centers are influenced primarily by payor source and payor mix of residents, which is the proportion of residents whose care is funded through the federal VA per diem, Medicaid, Medicare, or private pay. Reimbursement rates and eligibility criteria vary significantly across these funding streams, so modest shifts in the mix of residents can materially affect revenues of veterans' centers.

For example, Kentucky veterans care facilities with higher concentrations of private-pay residents generally operate with tighter margins because Kentucky caps private-pay rates below the total cost of care to keep services affordable for veterans. Alternatively, facilities with larger shares of residents funded through the VA prevailing-rate per diem tend to perform somewhat better financially, and those with higher proportions of Medicaid-subsidized residents generate the most revenue of all. In 2023,

approximately 27 percent of residents were funded by Medicaid while 26 percent were funded by the VA and 22 percent were funded by private pay.

VA per diems, CMS reimbursements, and private-pay revenue averaged $560 of the $721 average cost of care for Kentucky's veterans' centers. The centers rely on a $161 per-day General Fund subsidy to make up the difference.

Regardless of the payor source mix, Kentucky's veteran facility costs are not fully covered and do not generate profit. VA per diems provides a baseline amount of federal funding for state veterans' homes but are designed only to supplement, not cover, the full cost of care. Given Kentucky's relatively high cost per patient day, averaging $721 as of May 2025, no Kentucky facilities realize a financial margin through federal payments, CMS reimbursements, or private-pay residents.[114]

The amount of funding from these sources averaged to approximately $560 per resident per day in 2025.[115] The facilities, therefore, must rely on additional general fund support to close the difference, which equated to approximately $161 per veteran per day in 2025. Without the state's $161 per day supplement, the facilities could not operate at current staffing and care levels. As the $161 gap applies to every new veteran admitted, adding more residents would increase total costs faster than it increases revenue.

KDVA reports that increasing admissions without changing reimbursement rates or payor mix would raise total costs faster than revenue, deepening reliance on state funds.

According to KDVA, increasing admissions without changing rates or payor mix would increase total costs without improving financial performance. The department stated that the only ways to reduce reliance on general funds would be to substantially increase private rates or to prioritize admissions based on payor source or acuity, neither of which KDVA considers acceptable policy. Moreover, prioritizing admissions based on payor source or acuity could be seen as discriminatory and generally goes against admitting veterans with the greatest need.[116]

Two narrow exceptions exist where higher occupancy can improve financial performance: qualifying for certain VA and CMS bed-hold payments and realizing limited economies of scale.

There are two narrow exceptions where increasing occupancy can reduce costs. Maintaining high occupancy thresholds can affect certain payments, such as VA and CMS bed-hold reimbursements, and can increase benefits from economies of scale. Bed-hold per diem reimbursement, however, can be an inconsistent form of revenue, difficult to budget for, and is generally small compared to other veteran center revenue sources. Likewise, economies of scale are, by their nature, difficult to forecast and can run philosophically counter to other veterans' long-term care goals.

VA Per Diem Reimbursement For Bed Holds

A *bed hold* reserves a resident's bed during short absences. The federal VA per diem is not provided but a reduced rate will be provided if a facility is at 90 percent or greater capacity.

A *bed hold* reserves a resident's bed during short absences such as hospitalization or therapeutic leave, ensuring the resident can

return to the same room. While necessary for continuity of care, bed holds directly reduce usable capacity because a held bed cannot be reassigned, even when empty. In these cases, the federal VA per diem payment typically assigned to that resident is not provided while the resident was a patient at another facility.[117]

To compensate state veterans' homes for this temporary loss of capacity and revenue, the VA will provide the facility's typical per diem payments for the resident during a bed hold if the facility is at 90 percent capacity.[118] In addition to capacity requirements, bed holds are also time limited. The VA will pay bed-hold per diems only for the first 10 consecutive days during which a veteran is admitted to a hospital.[119]

None of Kentucky's veterans' homes operate above 90 percent capacity and would be ineligible for bed-hold reimbursements. KDVA estimates the amount of reimbursement would be small relative to other revenue.

In practice, none of Kentucky's veterans' homes currently operate above 90 percent capacity, and are currently ineligible for per diem payments during resident bed holds.[120] A review of veterans' center occupancy rates from 2015 to 2025 found this to be true for all facilities across this time span. KDVA confirmed Kentucky veterans' centers have historically been ineligible to collect VA per diem reimbursements during bed holds and that residents do experience routine hospitalizations. However, the department estimates that the amount of per diem reimbursement would be small relative to the other revenue for the facilities.[121]

Kentucky does not track potential bed-hold revenue. Committee staff estimated the average and maximum annual revenue that may be generated from bed holds. Amounts are presented in table 3.2.

Estimate Of Average And Maximum VA Bed-Hold Per Diem Reimbursement

As Kentucky does not qualify for bed-hold reimbursement, it does not track potential bed-hold revenue. Staff also found no states that report bed-hold per diem revenue separately from aggregate VA per diem revenue to use as a proxy. To develop a better understanding of the financial impact of bed-hold eligibility, an estimate of average and maximum annual revenue that Kentucky's veterans' centers might generate from the VA bed-hold per diem payments was calculated. The estimate was based on state veteran center capacity data provided by KDVA, OIG hospitalization rate estimates for long-term care residents, VA bed-hold reimbursement regulations, and 2025 VA per diem prevailing rates for Kentucky veterans. Table 3.2 shows the factors affecting VA bed-hold reimbursement and staff estimates for both average and maximum bed-hold revenue.

Table 3.2
Staff Estimate Of Average And Maximum
VA Bed-Hold Per Diem Reimbursement
2025

Factors Affecting Bed-Hold Reimbursement	Residents, Hospitalization Rates, And Reimbursement Rates
100 percent Kentucky veterans' center system capacity	566 residents
90 percent Kentucky veterans' center system occupancy*	509 residents
Prevailing rate per diem for Kentucky in 2025	$513 per resident per day
Long-term care resident average hospitalization rate	25%
Maximum number of hospitalization days that the VA will reimburse	10 days
Annual VA bed-hold reimbursement at 25% hospitalization rate	Approximately $650,000 per year
Annual VA bed-hold reimbursement at 100% hospitalization rate**	Approximately $2.6 million

Note: VA = US Department of Veterans Affairs; Kentucky's total capacity will be 741 beds once all capital projects are complete, the Bowling Green Veterans Center is open, and unused double-occupancy beds are decertified.
* 90 percent occupancy is required in order for a state veterans' home to qualify for VA bed-hold reimbursement.
**100 percent hospitalization rate presented to establish a theoretical maximum.
Source: LOIC staff analysis of data related to Kentucky veterans' center system occupancy and capacity. Provided to staff on August 18, 2025.

According to VA and KDVA reporting, the average prevailing rate per diem for Kentucky's state veterans' centers is approximately $513 per resident per day.[f] [122] Kentucky is currently certified by the VA for 818 beds and the VA will not provide funding for any beds beyond this limit. However, Kentucky's current maximum licensed and certified capacity, once the RVC HVAC project is complete and once BGVC is open will be 741 certified beds. As discussed in the previous section, this report recommends decertifying beds that are currently unused due to a transition to single-occupancy, which reduces this total to 566 beds. The VA requires facilities to reach 90 percent occupancy in order to qualify for bed-hold reimbursement, which would be 509 residents if averaged across Kentucky's facilities.

The average estimated revenue for bed holds would be approximately $650,000 but the annual revenue would likely be lower because consistently meeting those circumstances would be unlikely.

Average VA Per Diem Bed-Hold Estimate. According to a 2013 report by the HHS Office of Inspector General, nursing homes transferred about one quarter of their Medicare residents to hospitals for inpatient admissions.[123] In addition, the VA will only reimburse a state home for a maximum of 10 consecutive days of bed-hold per diem per veteran hospitalization.[124] Assuming a 25 percent hospitalization rate, one hospitalization per year, and the highest possible length of hospital stay reimbursable by the VA (ten days), Kentucky's potential annual VA bed-hold per diem

[f] Calculated from an average of each Kentucky veterans' center VA prevailing rate for 2025. Thomson-Hood: $532.60, Eastern KY: $491.95, Radcliff: $536.00, Western KY: $491.95.

revenue, assuming consistent 90 percent occupancy and that all eligibility criteria are met, would be approximately $650,000 per year.[g]

In practice, annual revenue would almost certainly be lower for a number of reasons. For example, not all hospitalized residents remain in the hospital for the full ten days and, even under ideal circumstances, all facilities may not operate above the 90 percent occupancy threshold required for reimbursement at all times. In addition, not all residents requiring hospitalization will qualify for the VA prevailing rate per diem. In which case their daily bed-hold per diem rate while hospitalized would drop from the prevailing rate of $513 to the basic rate of $144 per day.[125]

Theoretical Maximum VA Per Diem Bed-Hold Estimate. The theoretical maximum revenue from bed-hold payments would be approximately $2.6 million if every individual resident were receiving the prevailing rate and was hospitalized for the maximum ten possible days every year. However, in practice, this represents a purely hypothetical and virtually unattainable upper limit used solely to illustrate the outer boundary of potential revenue, as it assumes 100 percent occupancy, universal prevailing-rate eligibility, and full utilization of all allowable hospital days.

CMS will also pay bed hold during hospitalizations. When facilities operate at 95 percent occupancy, they are reimbursed at 75 percent of the daily Medicaid rate. When facilities operate at less than 95 percent occupancy, they receive 50 percent of the rate.

CMS Medicaid Reimbursement For Bed-Holds

Similar to the VA, Kentucky Medicaid pays bed-hold per diems during a resident's temporary hospitalizations. Federal law only requires that states elect this option, as Kentucky has, in their Medicaid state plan. Under CMS rules, facilities may receive reimbursement for up to 14 days of hospitalization per resident. When a facility is operating at 95 percent occupancy, Medicaid reimburses bed-holds at 75 percent of the daily Medicaid rate; at lower occupancy levels, reimbursement falls to 50 percent.[126] For FY 2025, Kentucky's daily Medicaid reimbursement rate is $762, making a hypothetical 75 percent bed-hold rate approximately $571 per day.

Table 3.3 provides the information on how CMS Medicaid bed-hold reimbursement works and estimates for both the average and maximum amount of Medicaid bed-hold reimbursement revenue that might be available to OKVC if the veterans' center system were to meet occupancy requirements.

[g] This calculation was made by taking 509 residents as 90 percent capacity for all Kentucky veterans' centers.

Table 3.3
Staff Estimate Of Average And Maximum
CMS Medicaid Bed-Hold Reimbursement
2025

Factors Affecting Medicaid Bed-Hold Reimbursement	Residents, Hospitalization Rate, And Reimbursement Rate
Kentucky veterans' center system occupancy	378 residents
Kentucky veterans' center system Medicaid eligible population	105 residents
Estimated number of Medicaid eligible residents at 95 percent occupancy*	151 residents
Long-term care resident average hospitalization rate	25 percent
Maximum number of hospitalization days that CMS will reimburse	14 days
75% of Kentucky's Medicaid reimbursement rate**	$571 per resident per day
Annual Medicaid bed-hold reimbursement at 25 percent hospitalization rate.	Approximately $300,000 per year
Annual Medicaid bed-hold reimbursement at 100 percent hospitalization rate.***	Approximately $1.2 million

Note: CMS = Centers for Medicare and Medicaid.
*95 percent occupancy is required for CMS bed-hold reimbursement at 75 percent; the estimated number of Medicaid eligible residents at that occupancy rate is 151.
**CMS will only reimburse facilities for bed holds at a 75 percent rate. Kentucky Medicaid reimbursement rate is $762 per resident per day. Seventy-five percent of this rate is $571 per resident per day.
***100 percent hospitalization rate presented to establish a theoretical maximum.
Source: LOIC staff analysis of data for Kentucky veterans' centers system occupancy and capacity. August 18, 2025.

KDVA also does not track Medicaid bed-hold data. An analysis similar to the VA per diem bed holds was used to calculate potential revenue.

Estimate Of Average And Maximum Medicaid Bed-Hold Per Diem Reimbursement

As KDVA does not track Medicaid bed-hold data, staff estimated potential reimbursement using the same methodology applied to VA bed-hold per diem calculations. Using the OIG's 25 percent hospitalization rate, as applied in the VA bed-hold analysis, and assuming each hospitalization uses the full 14 days of Medicaid-reimbursable bed-hold coverage, staff next estimated the number of Medicaid-eligible residents in a hypothetically 95 percent full veterans' center system.

An estimated average Medicaid bed-hold rate would be approximately $300,000 per year.

As of May 2025, 105 of 378 residents (about 28 percent) were Medicaid-eligible. A statewide census of 538 residents is required to reach 95-percent occupancy; applying the 28-percent Medicaid-eligible share results in an estimated 151 Medicaid-eligible residents in a 95 percent full system. Assuming a 25-percent hospitalization rate and 14-day stays, 151 Medicaid-eligible residents would generate approximately 529 Medicaid-reimbursable bed-hold days annually. At the 75-percent reimbursement rate (about $571 per day), this equates to roughly $300,000 per year in potential Medicaid bed-hold reimbursement revenue.

A theoretical maximum for CMS Medicaid bed-hold reimbursement would require every Medicaid-eligible resident to

experience a hospitalization each year and to use all 14 reimbursable bed-hold days. This unrealistic scenario yields an estimated 2,114 bed-hold days and approximately $1.2 million in revenue. As with the VA bed-hold theoretical maximum, this estimate is presented only to illustrate the upper bound of potential revenue and does not reflect a plausible operational outcome.

State Funding Required To Reach 90 Or 100 Percent Capacity

To receive bed-hold reimbursements, facilities would need to reach at least 90 percent capacity. This would require additional General Fund appropriations to support the new residents brought into the system.

To put estimated VA and CMS bed-hold revenue in context, this section examines how much it would cost the state to qualify for them. The number of occupied beds needed to reach 90 percent and 100 percent capacity across the Kentucky veterans' center system is 509 and 566 beds respectively, assuming all capital projects are complete, all facilities are operating, and all unused double-occupancy beds have been decertified. Kentucky veteran's centers had an occupancy of 378 residents across all facilities as of May 2025. Therefore, the system would need to increase its occupancy by 131 residents to reach 90 percent capacity and qualify for the VA bed-hold reimbursement or 188 beds to reach 100 percent capacity.

Assuming the current rate of $161 in general funds per resident per day, reaching 90 percent occupancy would cost an additional $8 million per year.

As the state currently supplements veterans' long-term care costs at the average rate of $161 per resident per day, the cost to the state of reaching 90 percent occupancy would be approximately $8 million per year. Meanwhile, reaching 100 percent occupancy would cost the state about $11 million per year. Table 3.4 shows current veteran center occupancy and the number of residents needed to reach 90 and 100 percent occupancy. The table shows the costs to the state associated with reaching these occupancy rates given the difference between total cost of care and federal funding.

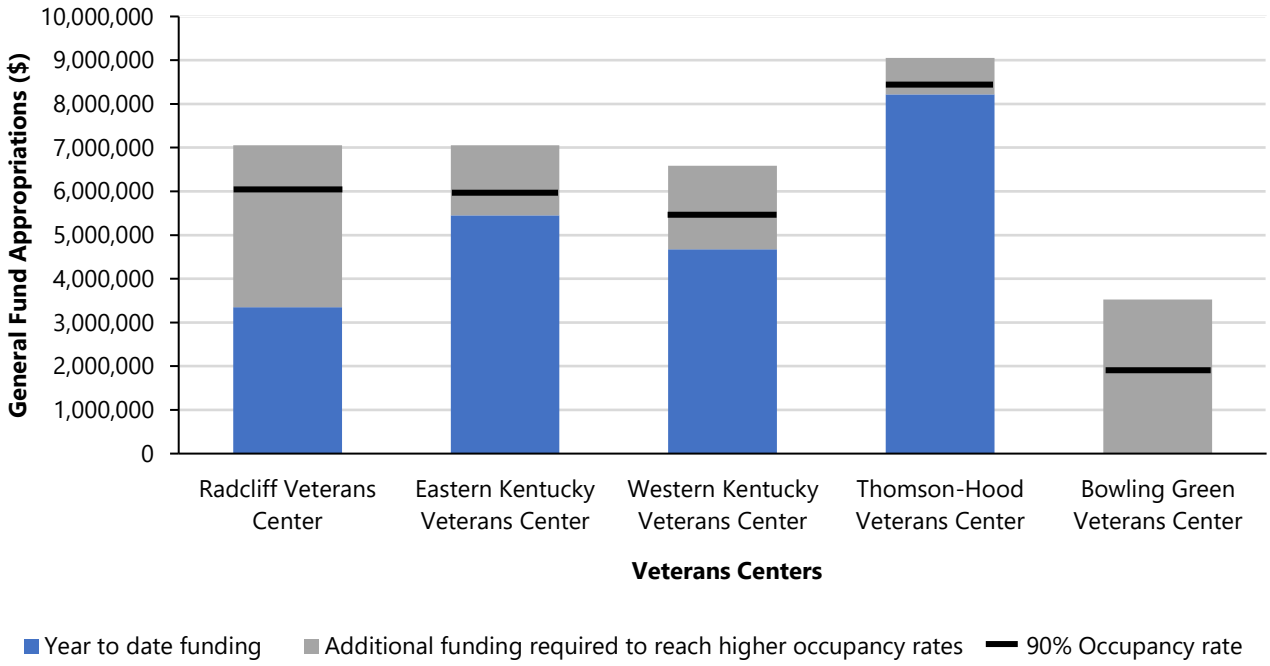
Table 3.4
Staff Estimate Of State Funding Required To Reach 90 And 100 Percent Occupancy

Occupancy	Residents	Annual Cost
Occupancy as of May 2025	378	$22 million
Additional residents needed to reach 90 percent occupancy	131	8 million
Occupancy at 90 percent capacity	509	30 million
Additional residents needed to reach 100 percent occupancy	188	11 million
Occupancy at 100 percent capacity	566	33 million

Note: The total cost of care per patient is approximately $721 per resident per day. Kentucky's portion of the cost is approximately $161 per resident per day.
Source: LOIC staff analysis of data related to the occupancy and the capacity of the Kentucky veterans' center system. Provided to staff on August 18, 2025.

Figure 3.B shows the amount of additional general fund support that would be needed at each veterans' center facility in order to reach 90 and 100 percent occupancy rates. Due to a capital project limiting its capacity to 50 percent, Radcliff will need to nearly double its occupancy to reach 90 percent, while the unopened Bowling Green facility will need to fill almost all of it capacity. Kentucky's three other facilities will need to increase occupancy more modestly.

Figure 3.B
State Funding Needed To Reach 90 And 100 Percent Capacity
At Kentucky Veterans' Centers
May 2025



Note: This assumes general fund support would be $161 per resident per day.
Source: Staff analysis from data provided by KDVA on August 16, 2025.

Total Funding, Revenue, And Expenditures

Kentucky veterans' centers are funded through KDVA, which receives funding from state and federal sources.

To put potential revenue from bed holds in context with respect to the additional funding needed to raise Kentucky veterans' center occupancy to 90 or 100 percent, the following section provides a review of overall funding for KDVA and Kentucky veterans' centers. Kentucky veterans' centers are funded through KDVA which receives funding from both state and federal sources. OKVC, which functions within the Office of the Commissioner of KDVA, manages the operations of state veterans' nursing homes

and distributes state funding.[127] This funding comes in the form of VA per diem payments, Medicare reimbursements, Medicaid reimbursements, private payment from residents or their insurance, as well as, state general fund support.[128] KDVA also receives federal and private funding assistance for the new construction or facility expansion or renovation.[129]

Federal Funding Mechanisms

The VA provides funding to states through three primary mechanisms.[130] VA construction grants to states to construct, acquire, remodel, or modify homes; payments to states for the hiring and retention of nurses; and per diem payments to reimburse states for eligible veterans receiving care in homes that are recognized and certified.[131]

The VA covers up to 65 percent of the cost to build, acquire, remodel, or renovate state veterans' homes.

Construction Grants. The VA covers up to 65 percent of the cost to build, acquire, remodel, or renovate state veterans' homes through a competitive construction grant program. Projects must meet all regulatory requirements and rank high enough on the VA priority list to receive funding. Grants are awarded to the state and paid in installments through reimbursement as construction progresses. States have five years to complete a project. In order to qualify for VA construction grants, facilities must ensure that 75 percent of their resident population with be composed of veterans.[132]

States operating veterans' homes may apply for payments to support nurse hiring and retention efforts to reduce staff shortages.

Hiring And Retention Assistance. 38 CFR pt.53 allows states operating VA-certified state veterans' homes to apply for federal payments to support nurse hiring and retention efforts aimed at reducing staffing shortages. To qualify, a state must demonstrate a nursing shortage and establish an approved employee incentive program. Applications are reviewed and approved by the VA Director of Geriatrics and Extended Care Operations.

The VA provides daily per diem payments for each eligible veteran receiving care in a certified facility. For each veteran with a service-connected disability rating, facilities receive an average prevailing rate of $513 per resident per day. For each other veteran, facilities receive a basic per diem rate of $144 per resident per day.

Resident Per Diem Payments. The veteran per diem is the primary mechanism by which the federal government supports state veterans' homes. The VA provides daily per diem payments to states for each eligible veteran receiving care in a certified facility.[133] All of the Kentucky veterans' centers qualify for this program under federal regulations.[134] It is divided into basic and prevailing rates, with basic rates providing a nationally standardized daily rate paid for eligible veterans who do not qualify for the higher prevailing rate. The prevailing rate is a higher, regionally adjusted rate paid for veterans who meet certain criteria, primarily those with a service-connected disability rating

of 70 percent or higher. As of FY 2025, the basic per diem rate for nursing home care is $144 per resident per day while the average prevailing rate for Kentucky is $513 per resident per day**.** Veterans in Kentucky state homes either receive the basic rate or the prevailing rate but not both.

State Funding Mechanisms

The General Assembly awards funding to KDVA and the veteran centers in its biennial budgets. Each veteran center receives a share of state funds based on the relative size of its payroll. The formula is adjusted for disparity between facilities' restricted fund revenue.

The General Assembly awards funding to KDVA and Kentucky veterans' centers via biennial budgets. KDVA then distributes these funds internally across its divisions based on baseline budgets and projected need. OKVC, the KDVA division that oversees veterans' centers, then takes this allocated portion and divides it among the individual facilities. Each facility receives its share of state funds based on how large its payroll is relative to the total payroll of all facilities. A facility's payroll is primarily determined by its occupancy and the acuity of its residents.

This formula is further adjusted to account for any disparity between a facility's restricted fund revenue of VA per diems, Medicaid reimbursements, and private pay from its residents and its actual operating expenses. State General Fund support is used to fill the gap between a facility's costs and its restricted revenue, with facilities that generate less revenue relative to their expenses receiving more state support to offset the difference.

KDVA And Kentucky Veterans' Centers Funding, 2020 To 2024

From FY 2020 to FY 2024, appropriations to KDVA averaged approximately $100 million annually.

KDVA Funding. Total appropriations to KDVA from FY 2020 to FY 2024 were reviewed. These amounts represent the total funds authorized by the General Assembly for KDVA expenditures each fiscal year. Appropriations over this time averaged about $100 million annually, with restricted funds serving as the primary source of revenue and general fund support remaining a stable secondary source of funding. General fund appropriations averaged $27.9 million and restricted funds averaged $71.0 million per year.

Restricted funds consist primarily of revenues from Medicare and Medicaid reimbursements, VA per diem payments, and resident payments. General funds reflect appropriations from the General Assembly to support KDVA operations not covered by restricted funds. Federal funds include occasional direct grants or reimbursements from the VA that are not part of restricted fund revenue.

Total funding declined in 2022, from $102 million to $94 million, largely due to a decrease in restricted funds as a result of decreased occupancy rates during the COVID pandemic.

Total funding declined in 2022, from $102 million to $94 million, largely due to a decrease in restricted funds as a result of decreased occupancy rates during the COVID pandemic. This decline led to decreased Medicaid reimbursement and VA per diems.

The largest year-over-year increase occurred in FY 2023, when total appropriations rose from approximately $94 to $100 million. This was largely driven by an increase in general fund support which was put into place to cover the gap in federal and personal revenue that the facilities were experiencing as they recovered from COVID and worked to recover occupancy. As of 2024, restricted funds remain lower than they were pre-pandemic but general fund support has remained high. This additional general fund support has been enough to maintain KDVA funding at roughly $100 million. Table 3.5 lists total federal and state appropriations to KDVA from 2020-2024.

Table 3.5
Kentucky Department Of Veterans' Affairs Appropriations
FY 2020 To FY 2024

Appropriation	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
General funds	$25,810,200	$26,060,400	$26,121,400	$30,092,600	$31,333,500
Restricted funds	78,964,500	73,788,700	68,075,600	67,154,900	67,003,500
Federal funds	0	2,958,000	500,000	2,433,600	0
Total	$104,774,700	$102,807,100	$94,697,000	$99,681,100	$98,337,000

Source: Kentucky. General Assembly. *Acts Of The 2018 General Assembly*, ch. 169, p. 1291; *Acts Of The 2020 General Assembly*, ch. 92, p. 853; *Acts Of The 2022 General Assembly*, ch. 199, p. 1635; *Acts Of The 2024 General Assembly*, ch. 175, pp. 1806-1807.

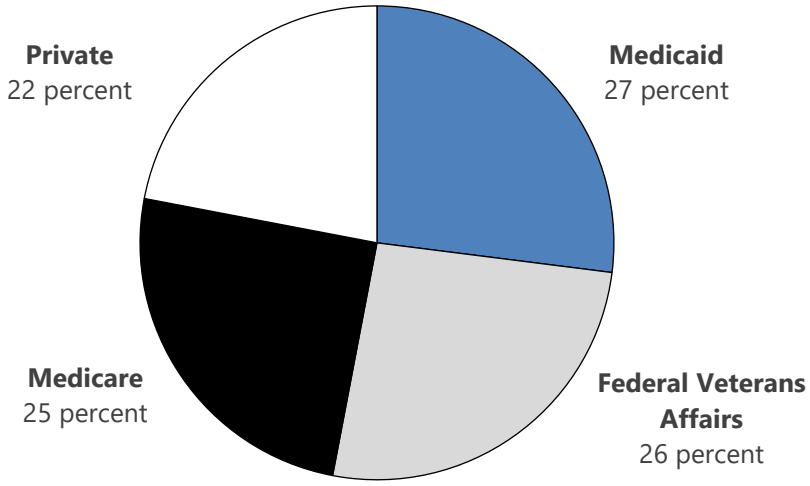
OKVC (Veterans' Centers) Funding. After money is awarded to KDVA, funds are then allocated to OKVC for the operations of, among other things, Kentucky veterans' centers. Table 3.5 provides a detailed accounting of how the restricted funds and a portion of general funds are generated and received at Kentucky veterans' centers.

From 2020 to 2024, OKVC had an average of $79 million in revenue annually.

From 2020 to 2024, OKVC has averaged around $79 million in revenue annually and total revenue equaled approximately $89 million in 2024. The largest source of revenue comes from resident care revenue in the form of VA per diems, CMS reimbursements, resident private pay and resident private insurance coverage. This represented approximately 70 percent ($62 million) of Kentucky veteran center funding in 2024. Figure 3.C shows the payor mix (sources of revenue) for Kentucky veterans' centers as of 2023. VA per diem payments, Medicaid, Medicare, and private payments

from residents or their insurance provider each made up about a quarter of residential care revenue.

Figure 3.C
Revenue For Kentucky Veterans' Centers
By Payor Source
2023



Source: Kentucky Department of Veterans' Affairs *FY23 Annual Report*.

State general fund support contributed almost all of the remaining 30 percent ($26 million) in 2024 and is included in table 3.5 as "other revenue". The average amount of state funding from 2020 to 2024 was approximately $24 million. "Other revenue" reflects federal and private pay for services like occupational therapy, speech therapy, and physical therapy and represents a modest amount of annual revenue. Table 3.6 lists revenue sources for OKVC and Kentucky's veterans' centers.

Table 3.6
Kentucky Veterans' Centers Revenue
FY 2020 To FY 2024

Revenue Source	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Resident care revenue	$63,050,711	$53,430,282	$44,161,970	$49,841,229	$61,833,747
Other revenue	19,623,214	23,905,335	20,834,303	29,668,582	26,064,858
Ancillaries	949,053	810,598	677,506	719,824	772,851
Total	$83,622,978	$78,146,215	$65,673,779	$80,229,635	$88,671,456

Source: Mark Bowman, executive director, Office of Kentucky Veterans' Centers. Information request response to Legislative Oversight and Investigations Committee staff, May 28, 2025. Email to Shane Stevens, August 16, 2025.

Total Funding Context For Bed Holds And Full Occupancy

As discussed previously, the estimated amount of state funding required to reach 90 and 100 percent occupancy at Kentucky veterans' centers is approximately $8 and $11 million, respectively. This would represent a 33 percent increase (at 90 percent occupancy) or a 46 percent increase (at 100 percent occupancy) in OKVC general fund support ($24 million).

In terms of bed-hold per diem revenue, the estimated $650,000 annual income, assuming a 25 percent hospitalization rate for residents, would represent only 0.8 percent of average Kentucky veterans' center revenue ($79 million). Alternatively, the theoretical maximum of $2.6 million, which is not practically attainable, would represent approximately 3.3 percent. Table 3.7 provides funding levels for OKVC and KDVA to provide context for increasing occupancy levels and pursuing bed-hold per diems.

Table 3.7
Office Of Kentucky Veterans' Centers Revenue, Estimated State Funding Required For Occupancy Increases, And Estimated Bed-Hold Revenue

Appropriations And Reimbursements	Funding	Percent Of State Funding/Revenue
Average state funding, 2020 to 2024	$24 million	-
State funding required to reach 90 percent occupancy	$8 million	33% of state funding
State funding required to reach 100 percent occupancy	$11 million	46% of state funding
Average OKVC revenue, 2020 to 2024	$79 million	-
VA Bed-Hold reimbursement estimate, 25 percent hospitalization	$650,000	0.8% of revenue
VA Bed-Hold reimbursement estimate, 100 percent hospitalization	$2.6 million	3.3% of revenue

Source: Staff analysis of Office of Kentucky Veterans' Centers revenue, United States Veterans Affairs policies, and Centers for Medicaid and Medicare Services policies.

Prevailing Rates, Total Cost Of Care, And Economies Of Scale

Kentucky veterans' centers are likely to always need General Fund support because of how rates are calculated. Prevailing rates are based on national and regional averages. Kentucky's total cost of care is $721 per resident per day while the prevailing rate is only $513.

Kentucky veterans' centers are likely to always need general fund support. This is because the VA prevailing rate is based on national and regional averages intended to represent a reasonable cost of care and place a cap on VA reimbursement, while Kentucky's total cost of care reflects the state's actual expenses. Kentucky's total cost of care for veterans, approximately $721 per resident per day as of May 2025, exceeds the VA prevailing rate of $513 per day. After accounting for resident private pay or insurance, this creates an average funding gap of about $161 per resident per day that must be covered through state General Fund appropriations.

Because the VA prevailing rate and Kentucky's cost of care are shaped by independent factors, the gap between them is unlikely to narrow meaningfully without major policy shifts related to resident quality of care, payor mix, or acuity mix.

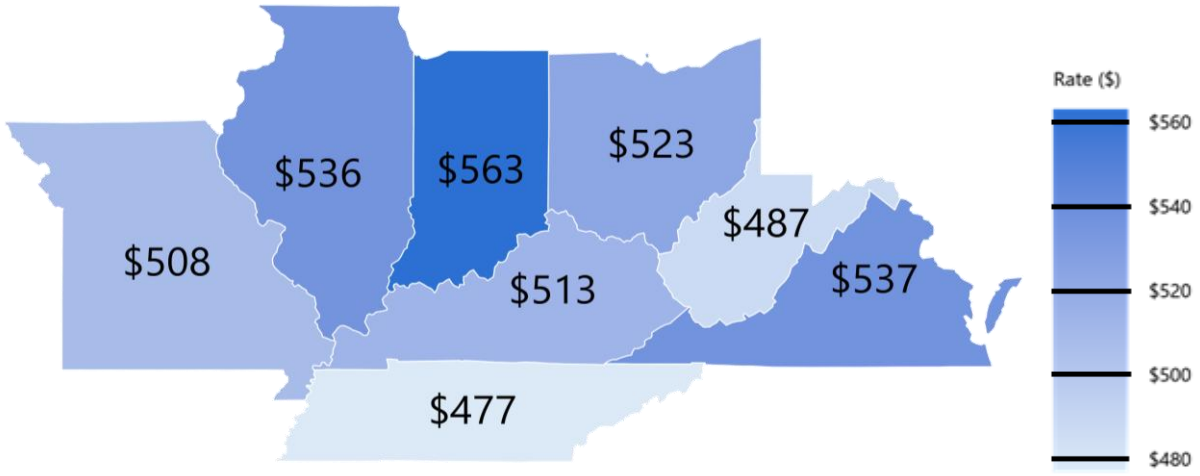
In effect, closing this gap would require Kentucky either to reduce the quality of care provided to veteran residents or to limit admissions based on resident payor source, level of acuity, or qualification for prevailing rate as opposed to basic rate. However, these policy shifts are not supported by KDVA, the VA, or CMS.

As a result, increasing occupancy or capacity may improve operational efficiency but is unlikely to ever increase revenue so long as federal reimbursement remains capped at a prevailing rate that has historically lagged behind actual cost of care at state veterans' homes.

Kentucky's prevailing rate is in line with other states in the region.

VA Prevailing Rates. VA prevailing rates represent what the VA recognizes as a reasonable average cost of providing care to a veteran in a state veterans' home. The average takes into account geographic area and national data and serves as a benchmark for maximum per diem reimbursement. Every facility's prevailing rate will differ. If a state veterans' home's documented cost of care exceeds the prevailing rate, the VA will cap reimbursement at the prevailing rate. If the cost is lower, reimbursement will be limited to the actual cost. Kentucky prevailing rates are in line with other states in the region. The average prevailing rate for Kentucky, Tennessee, Indiana, Illinois, Missouri, Michigan, West Virginia, Virginia, and South Carolina was $517 for 2025. Figure 3.D shows the prevailing rate for each state.[135]

Figure 3.D
Regional VA Prevailing Rates For Veterans' Care
As Of October 21, 2025



Source: Staff analysis of US Department of Veterans Affairs, "Geriatrics And Extended Care: State Home Per Diem Program." Oct. 21, 2025. Web.

The total cost of care in Kentucky exceeds the prevailing rate by approximately 41 percent. CMS reimbursements, private pay, and state funds make up the difference.

Total Cost Of Care. In contrast to prevailing rates, the total cost of care in Kentucky reflects the actual expense incurred to operate its veterans' centers. This includes expenses such as personnel, supplies, capital costs, and administration and exceeds the VA prevailing rate by roughly 41 percent. Together, CMS reimbursement, private pay, and state funds make up the difference.

The higher cost of veteran center care is attributable to differences in resident needs, facility design, and the level of services provided.

The higher cost of care at Kentucky veterans' centers compared to the VA's prevailing rate is primarily attributable to differences in resident needs, facility design, and the level of services provided. Kentucky's centers care for a population of veterans who often present with greater medical and behavioral health acuity than residents in typical community nursing facilities. This necessitates a higher level of clinical oversight, specialized nursing care, and therapy services. Some of this gap is reflected in the cost of ancillary services provided by OKVC and reported in Table 3.5. These additional therapies are, for the most part, not covered by VA per diems or reimbursed by CMS and so are supported mostly by state funds.

Staff-to-resident ratios at Kentucky veterans' centers are higher than those found in most private long-term care settings.

Staff-to-resident ratios at Kentucky veteran's centers are also higher than those found in most private long-term care settings. Additionally, Kentucky's newer and renovated facilities, such as Radcliff and the forthcoming Bowling Green center, are designed

around more modern models of care that prioritize single-occupancy rooms, larger square footage per resident, and greater infection control and privacy. These design and staffing priorities enhance the quality of life and clinical outcomes for veterans but also increase per-resident operating costs.[136]

The National Association of State Veterans Homes has reported that the prevailing rate lags behind total cost of care for states generally. Similarly, the Government Accountability Office has reported that states routinely fund the difference.

Other States And Revenue-Neutral Models. This difference between VA prevailing rate and state nursing home total cost of care is not unique to Kentucky. NASVH has reported to Congress that the VA prevailing rate lags behind total cost of care for states generally and behind average private long-term care providers.[137] Similarly, the Government Accountability Office has reported that VA per diem payments do not typically cover all of a state veterans' home's cost of care and that states routinely fund the remaining balance through state appropriations, resident payments, or Medicaid.[138]

Some states, such as Tennessee, require their veterans' homes be revenue-neutral.

Some states, such as Tennessee, require that their veterans' homes be revenue-neutral and not rely on state general fund support. Typically, regulatory language will require that the facilities only operate if there is sufficient revenue from the collection of resident payments, resident insurance, CMS reimbursement, and VA per diem reimbursement. As they cannot rely on state general fund support, these facilities are operated more like a private nursing facility that has to maximize revenue through payor mix.[139]

This model has drawbacks, as seen when the Tennessee State Veterans' Homes Board had to run a $1.1 million loss because of patient mix, lower occupancy, and expensive nurses. An audit found that its homes sometimes could not admit veterans even when beds were available.

This model has drawbacks, however. Tennessee recently had difficulties maintaining their revenue-neutral model. In late 2024, the Tennessee State Veterans' Homes Board (TSVHB) reported to the State Funding Board that they were running a $1.1 million loss because of patient mix, lower occupancy, and expensive agency nurses.[140] Further, in 2022, a performance audit of the TSVHB found that because the board does not receive state appropriations and relies only on self-generated revenue, limitations in staffing and resident admission can occur when operating revenues are insufficient to cover costs. In such cases, homes may be unable to admit veterans even when beds are available.[141] All of which indicates that states which adopt a revenue-neutral model for veterans' long-term care, must at some level admit and care for veterans in a way that prioritizes revenue through either payor mix, staffing, treatments offered, or quality of care.

The Tennessee State Veterans' Home Board reported its ability to remain revenue neural was accounted for entirely by centralization.

TSVHB reported that its ability to remain revenue neutral was accounted for entirely by efficiencies created by centralization. While staff have identified several benefits from centralization that may be effective for Kentucky, these would result in improvements

to operations rather than revenue. While there may be some financial efficiencies to be gained, it is unlikely that centralization efficiencies would close the 22 percent gap between OKVC total cost of care and its revenue streams.

KDVA and other state veterans' departments reported that higher occupancy rates generally improve efficiency due to economies of scale. They reported that efficiencies become meaningful when occupancy exceeds 100 beds, but this can result in staffing challenges.

Economies Of Scale. KDVA and several other state veterans' departments reported higher occupancy rates generally improve operational and financial efficiency due to economies of scale. These departments indicated that such efficiencies begin to become meaningful once a facility's occupancy exceeds approximately 100 beds. They also cautioned, however, that once capacities become too large, they often face increased challenges maintaining adequate staffing levels and sustaining high occupancy.[142]

Research on economies of scale have findings that are mixed and inconclusive.

There is some research on economies of scale in the broader long-term care sector, but findings are mixed and inconclusive. Some studies have identified cost efficiencies among smaller nursing facilities as fixed administrative and clinical costs are spread across more residents. However, these efficiencies tend to occur at scales smaller than that of Kentucky's veterans' centers, and many of these studies have been contested due to the wide range of variables influencing long-term care costs.[143] Factors such as resident acuity, behavioral health complexity, staffing availability, and quality-of-care objectives can all substantially affect operational costs.

Moreover, KDVA's quality-of-care standards, and those of Kentucky's veterans' centers, are very high and the veteran population they serve generally has higher acuity and behavioral health needs than the general population.[144] Also, in principle, the small-homes model and single-occupancy room model promoted by the VA, CMS, and KDVA intentionally sacrifice large scale efficiencies to improve resident quality of life and strengthen infection control.

Limited Revenue Optimization From Occupancy And Capacity Increases

Given the modest revenue potential from bed holds and per-patient costs, maximizing capacity would increase cost to the state rather than generate revenue for veterans' centers.

Given the modest revenue potential from VA bed-hold per diem payments, the persistent gap between VA prevailing rates and Kentucky's total cost of care, and the shared emphasis placed on quality of care over scale efficiency by the VA, CMS, and KDVA; maximizing occupancy or increasing capacity will likely increase the need for financial support from the General Assembly rather than generate additional revenue for veterans' centers.

Accordingly, any expansion in occupancy or capacity should be pursued with consideration of the increasing cost of caring for additional veterans and the primary goal for such expansions should be ensuring timely access to high-quality services. Revenue efficiencies that result from aligning certified and functional capacity should be regarded as a secondary benefit rather than a primary funding mechanism.

Matter For Legislative Consideration 3.A

Matter For Legislative Consideration 3.A

If it is the intent of the General Assembly to increase the number of veterans cared for at Kentucky veterans' centers, then the General Assembly may wish to plan for increased cost rather than increased revenue.

In addition to examining whether occupancy levels influence revenue, the following section evaluates whether capacity limitations may be denying Kentucky veterans access to care. When measured against functional rather than certified capacity, Kentucky's systemwide occupancy rate is approximately 85 percent, which is higher than national averages, yet leaves room for modest increases in census.

Identifying Kentucky Veterans' Centers Excess Capacity

Kentucky Veterans' Centers Staffing

Staffing is the primary operational factor shaping how certified and functional capacity can be used.

Staffing is the primary operational factor shaping how much of Kentucky's certified and functional capacity can be used. Across all four veterans' centers, staffing levels determine not only the census facilities can support today but also the pace at which additional residents can be admitted in the future. In 2024, staffing expenses represented 67 percent of Kentucky veteran center expenditures.[145]

Staffing declined during the COVID-19 pandemic, reaching a ten-year low of 432 positions in 2022. As of 2025, there were 615 positions filled and a personnel cap of 854 positions.

Staffing levels declined sharply during the COVID-19 pandemic, reaching a ten-year low of 432 positions in 2022. Since then, staffing has gradually improved. As of 2025, OKVC reported a systemwide personnel cap of 854 budgeted 18A positions, with 615 positions filled, a 72 percent fill rate. During the pandemic the centers began relying more on contracted and agency staff to supplement full-time staff, though KDVA has prioritized transitioning back to an increased reliance on 18A workforce.[146] Table 3.8 shows how staffing caps and filled positions have changed over time.

Table 3.8
Kentucky Veterans' Centers Staffing Positions Filled
2018 To 2025

Year	Positions Filled	Personnel Cap	% Filled Positions
2018	727	1,037	70%
2019	738	996	74
2020	699	978	71
2021	569	861	66
2022	432	793	54
2023	445	742	60
2024	578	812	71
2025	615	854	72

Source: LOIC staff compilation of data provided by Mark Bowman, executive director, Office of Kentucky Veterans' Centers, Kentucky Department of Veterans' Affairs. Email from KDVA to Shane Stevens, Sept. 16, 2025.

The increase in filled positions was attributed to special entry rates and locality premiums.

KDVA attributes part of this recovery to recent pay adjustments, including special entry rates and locality premiums, which have helped stem turnover and improve recruitment in regions that have historically seen staffing challenges. KDVA reports meaningful gains in filled positions since these measures were authorized by the General Assembly in 2021 and approved by the Personnel Cabinet and KDVA in 2023.[147] According to a KDVA FY 2023 Annual Report, filled 18A positions increased by 87 (18 percent) in the five months following implementation of these changes, with staffing increasing an additional 22 percent since then.[148]

The availability of nursing and support staff is heavily influenced by local labor markets. While KDVA reported that WKVC faces the most staffing challenges, it had filled 91 percent of staffing positions.

Statewide, the availability of nursing and support staff remains heavily influenced by local labor markets. KDVA reported to staff that, among Kentucky veterans' centers, WKVC faces the most persistent staffing challenges. However, the facility's staffing data indicates that the recent implementation of pay adjustments and increased funding may have stabilized staffing for the region. For 2025, KDVA reports that 91 percent of staffing positions at WKVC have been filled at the current personnel cap.[149]

WKVC reported that the personnel cap restricts its ability to admit more residents. OKVC reported there was not enough demand to sustain an increased personnel cap.

WKVC administration reports, however, that while their current allotted personnel cap is filled, the cap itself restricts their ability to reopen units and admit more residents. The current personnel cap was based on a limited projected census of 84 residents. Conversely, OKVC reported that, given WKVC's historical peak in census was 115 residents, there may not be enough regional demand to sustain an increased personnel cap.

Staffing levels appear generally strong across facilities. Table 3.9 shows personnel caps and filled positions for each veterans' center from 2018 through 2025. Staffing levels have fluctuated over this time period and suffered significant decreases during the COVID-19 pandemic, but all have improved in recent years. Among the other three facilities, RVC is the only veterans center with a staffing position fill rate below 85 percent. However, when staffing levels are adjusted to reflect RVC's temporary 50-percent reduction in capacity due to the ongoing HVAC capital project, the facility's fill rate increases from 74 percent to 85 percent.[150]

Table 3.9
Staffing Positions Filled
Adjusted For Functional Capacity
2018 To 2025

	Thomson-Hood			Eastern Kentucky		
Year	Filled	Cap	% Filled	Filled	Cap	% Filled
2018	291	361	81%	165	175	94%
2019	275	355	77	170	176	97
2020	261	323	81	169	175	97
2021	209	291	72	159	175	91
2022	160	272	59	121	170	71
2023	152	245	62	131	173	76
2024	194	241	80	156	172	91
2025	196	233	84	160	170	94

	Western Kentucky			Radcliff		
Year	Filled	Cap	% Filled	Filled	Cap	% Filled
2018	152	203	75%	119	260	46%
2019	144	198	73	149	260	57
2020	133	180	74	136	218	62
2021	109	166	66	92	198	46
2022	86	158	54	65	189	34
2023	84	167	50	78	155	50
2024	126	167	75	102	155	66
2025	148	163	91	111	150	74 (85)*

Note: Cap = capacity.
* The Radcliff Veterans Center is current undergoing a capital project that has reduced its capacity by 50 percent. Adjusting for this capacity reduction gives the facility an 85 percent staffing positions filled rate.
Source: LOIC staff compilation of data provided by Mark Bowman, Executive Director, Office of Kentucky Veterans' Centers, Kentucky Department of Veterans' Affairs. Email from KDVA to Shane Stevens, Sept. 16, 2025.

Kentucky Special Entry Rates And Locality Premiums

In recent years, KDVA has implemented several measures to improve staff recruitment and retention at its veterans' centers.[151]

These efforts have focused primarily on special entrance rates (SERs) for nursing staff and premium pay incentives, particularly locality pay.[152] These measures appear to have been effective.

In June 2023, special entrance rates were set for nursing staff at veterans' centers.

Special Entrance Rates. In June 2023, Kentucky approved higher starting pay for nursing staff at its veterans' centers.[153] When a special entrance rate is set for a job, anyone in that job who earns less than the new starting rate must have their salary raised to meet it.[154] Agencies may also give a proportional increase to all employees in that job category so that everyone moves up in line with the new starting rate.[155]

In March 2023, KDVA began using locality premiums to help hiring at veterans' centers. These are extra pay for categories of staff paid on top of regular wages.

Locality Premiums. In March 2023, KDVA began using "locality premiums" more often to help fix hiring and retention problems at Kentucky's state veterans' centers.[156] A locality premium is an extra payment the Personnel Cabinet Secretary can approve when an agency shows it is struggling to hire or keep staff.[157] Once approved, the premium is added for every employee of that type.[158] Locality premiums are paid on top of regular wages.[159]

Staffing rose from 397 positions in February 2023 to 484 positions in July 2023.

Impact Of Special Entry Rates And Locality Premiums. Staffing levels among 18A merit employees at Kentucky veterans' centers increased substantially in 2023 following implementation of special entry rates, locality premiums, and other targeted pay adjustments approved by the Personnel Cabinet and implemented by KDVA. According to KDVA the number of filled 18A full-time positions across the four centers rose from 397 in February 2023 to 484 by July 2023. Each facility experienced gains during this period, with Eastern Kentucky Veterans Center showing the largest increase, followed by smaller but meaningful improvements at Radcliff, Thomson-Hood, and Western Kentucky.[160]

KDVA attributes these staffing gains directly to locality premiums and special entry rates which allowed facilities to better match surrounding private-sector and hospital-sector pay rates, improving recruitment and retention. The rapid growth in filled positions after the implementation of these measures and the high levels of staffing positions filled in 2025 indicates that compensation adjustments were an effective strategy for rebuilding the 18A workforce.

If the General Assembly is interested in increasing occupancy, additional staffing may be needed.

If the General Assembly is interested in adding more residents to facilities, or potentially creating new facilities, additional staff will likely be needed. Given the effect of the SERs and locality premiums, similar measures may be needed to continue adding to the staffing roster.

Recommendation 3.3

Recommendation 3.3

The Kentucky Department of Veterans' Affairs should work with the Kentucky Personnel Cabinet to evaluate whether staffing incentives, in the form of special entry rates and locality premiums, are sufficient or should be expanded for each Kentucky veterans' center region.

National Comparison. The number of positions filled at a Kentucky veterans' centers does not, by itself, indicate whether staffing levels are sufficient to meet resident care needs. OKVC internally allocates staffing positions based on historical patterns, facility budgets, and administrative priorities.[161] When a facility reports that it has filled its authorized positions, it simply reflects that the center has met its internal staffing plan, not that the plan aligns with clinical demand, resident acuity, or federally recognized staffing benchmarks.

CMS conducts staffing evaluations that provide a measure of staffing adequacy. These compare state centers to private and public long-term care providers.

CMS staffing evaluations provide an external, resident-centered measure of staffing adequacy.[162] Figure 3.10 shows CMS metrics on nurse hours per resident, nursing turnover, and the overall staffing rating for each Kentucky facility, which includes additional metrics. For each metric, a comparison point of the state and national average for long-term care providers, both state veterans' facilities and private care facilities, is provided.

Staffing ratings for Kentucky veterans' centers exceed state and national averages on nearly every CMS metric.

The staffing ratings for Kentucky state veterans' centers exceed state and national averages on nearly every CMS metric. CMS assigns each facility a staffing rating on a five-star scale; while both the national and state averages are three stars, all four Kentucky facilities receive a rating of five stars. Kentucky's centers also deliver more daily nurse hours per resident than the state and national averages. Nursing turnover rates are generally lower than statewide and national levels, though WKVC and RVC remain roughly in line with, or slightly above, those broader averages.

Figure 3.10
Staffing Evaluation Metrics From
The Centers For Medicare And Medicaid Services
2024

Staffing Metrics	EKVC	RVC	THVC	WKVC	State Average	National Average
Daily nurse hours per resident	5.2	5.8	5.2	5.6	4.0	3.9
Nursing turnover	12.5%	47.4%	20.7%	47.9%	47.0%	46.9%
Overall rating, 1 to 5	5	5	5	5	N/A	3

Note: EKVC = Eastern Kentucky Veterans Center; RVC = Radcliff Veterans Center; THVC = Thomson-Hood Veterans Center; and WKVC = Western Kentucky Veterans Center.
Source: United States. Centers for Medicare and Medicaid Services, "Paul E Patton Eastern KY Veterans Center." nd. Web; United States. Centers for Medicare and Medicaid Services, "Carl M Brashear Radcliff Veterans Center." nd. Web; United States. Centers for Medicare and Medicaid Services, "Thomson-Hood Veterans Center." nd. Web; United States. Centers for Medicare and Medicaid Services, "Joseph Eddie Ballard Western KY Veterans Center." nd. Web; Mark Bowman, executive director, Office of Kentucky Veterans' Centers. Data request response to Legislative Oversight and Investigations Committee staff, August 16, 2025. Email to Shane Stevens, August 16, 2025.

2025 Kentucky Veterans' Center System Excess Capacity

Kentucky's systemwide functional occupancy rate of 85 percent is high compared to the national average but leaves room for modest gains.

While staffing levels appear to have stabilized and are sufficient to meet current operational needs, a remaining question is whether existing capacity and occupancy levels meet demand for long-term care among Kentucky veterans. The systemwide functional occupancy rate of 85 percent exceeds national averages, yet leaves room for modest increases in occupancy.

As of May 2024, THVC and RVC are operating near maximum functional capacity. Until the HVAC replacement at RVC is complete, at most 15 residents could be added.

As of May 2025, THVC (92 percent functional occupancy) and RVC (95 percent functional occupancy) are already operating near their maximum functional capacity. Further gains at these facilities would yield only minimal increases, at most 15 additional residents until the HVAC replacement at RVC is complete.[163] This number would also likely fluctuate from month to month due to normal variations in resident turnover, admissions, room availability, and application processing times.

EKVC, at 80 percent functional occupancy, and WKVC, at 74 percent functional occupancy, have a greater capacity to admit additional veterans. However, EKVC's current occupancy is based entirely on double-occupancy rooms.[164] If KDVA intends to pursue a systemwide transition to single-occupancy rooms, efforts to increase EKVC's census should be balanced against this long-term objective.

While WKVC has the largest amount of open capacity, staffing shortages remain a limiting factor to increase the number of residents.

Among currently operational facilities, WKVC has the largest amount of open functional capacity under a single-occupancy model; however, as noted previously, KDVA reports that staffing shortages remain a limiting factor. KDVA indicated that it plans to request additional funds for staffing at WKVC in the next budget cycle.[165] The report recommends that the department also work with the Personnel Cabinet to pursue higher special entry rates and locality premiums to improve recruitment and retention as well. Until those adjustments take effect, the facility will likely struggle to reach full functional capacity.

KDVA expects the new BGVC to reach 90 percent occupancy within two years of opening.

The opening of the BGVC in 2026 will increase Kentucky's systemwide operational capacity by 60 beds. Occupancy rates at this facility remain to be determined, but KDVA and BGVC administrators project that it will reach greater than 90 percent occupancy within 2 years of opening.[166] State staffing caps, however, will need to be significantly increased.

Given the consistently high occupancy at THVC and RVC, and the unique constraints limiting growth at EKVC and WKVC, it is possible that new construction or the expansion of existing facilities may be needed to significantly increase Kentucky veterans' center system capacity beyond the additional capacity provided by BGVC. However, a better understanding of demand, in the form of veteran applications and waitlists is needed in order to determine Kentucky's need for additional functional capacity.

Chapter 4

Is There Unmet Demand For Long-Term Veteran Care?

This chapter review facility admissions procedures and decision logs to identify why applicants are deferred or denied admission and to determine whether limited capacity is a factor.

This chapter reviews facility admissions procedures and decision logs to identify why applicants are deferred or denied admission and to determine whether limited capacity is a contributing factor. The chapter then evaluates facility waiting lists in order to determine how many veterans are waiting for admission, how long they are waiting, and whether capacity constraints influence placement on these lists. As the Kentucky veterans' centers and the Kentucky Department of Veterans' Affairs do not maintain formal waiting lists and admissions decisions are inconsistently documented, the analysis also draws on broader demographic trends in Kentucky's veteran population as a proxy for potential long-term care demand.

Throughout the chapter, challenges related to rising patient acuity and behavioral health care needs are examined, as interviews, information requests, and admissions data indicate these issues are major drivers of admissions decisions, occupancy rates, and ongoing operational strain on veterans' centers staff. The chapter also assesses how admissions information is communicated, both between individual facilities and applicants and between KDVA and the legislature. The chapter concludes with a review of quality-of-care metrics on Kentucky veterans' centers.

Admissions Procedures And Waiting Lists

Admissions Procedures

Admission begins with an application package. Applications are reviewed for eligibility and clinical appropriateness. Applicants may be placed on a waiting list if beds are not available, the applicant is not ready, or forms require additional review.

Admission to a Kentucky veterans' center generally begins with an application package submitted by the veteran, a family member, or a referring provider. Applications are reviewed for eligibility based on their veteran status, medical necessity, level of care, and financial and payer information. Applications are also reviewed for clinical appropriateness based on the veteran's needs and unit availability, such as secure units. When a suitable bed is not immediately available, the applicant's needs require additional vetting, or the applicant is not personally ready to enter the facility, applicants may be placed on a waiting list.[167]

Admissions are governed by US Department of Veterans Affairs (VA) requirements, Centers for Medicare and Medicaid Services (CMS) rules, and state statutes and regulations. Applicants must be a Kentucky resident, a veteran, and in need of long-term care.

Admissions to Kentucky veterans' centers are governed by a combined framework of federal Department of Veterans Affairs (VA) requirements, Centers for Medicare and Medicaid Services (CMS) nursing-facility rules, and state statutes and regulations.[168] KRS Chapter 40 and 17 KAR establish Kentucky's baseline requirements for admission. The applicant must be a Kentucky resident, a military veteran, and in need of long-term care. Table 4.1 lists the major federal and state laws and regulations that govern admission to veterans' long-term care facilities.

Table 4.1
Federal And State Admissions Requirements For Veterans' Long-Term Care Facilities In Kentucky

Governance Language	Level Of Governance	Governance Citation
Veterans qualify if they need nursing care, remain eligible for VA benefits, and are not barred by law. They must have service-connected disability or be willing to pay co-payment.	VA	38 CFR 51.50
Veteran must be a Kentucky resident with non-dishonorable discharge who needs nursing care due to disability, illness, or age. Veterans whose needs cannot be met by the center are ineligible for admission.	State	17 KAR 3:042
Facilities conduct preadmission screening and resident review to screen for mental illness or intellectual disability.	CMS; State	42 USC. 1396; 907 KAR 1:022
Facilities may not discriminate based on race, color, national origin, sex, age, or disability; room assignment by sex is permitted by state law.	CMS; VA; State	42 USC 18116; KRS 344.120; KRS 344.145
Facilities must apply identical policies to all residents regardless of payment source.	CMS; VA; State	42 CFR 483.15; 38 CFR 51.80
Written policies must prohibit waiver of legal rights, liability waivers, or third-party payment guarantees.	CMS; VA	38 CFR 51.80; 42 CFR 483.15.
Residents must receive clear explanations of benefits, payment policies, refunds, and application procedures. Facilities must disclose all services, rights, responsibilities, and charges before admission.	CMS; VA; State	38 CFR 51.70; KRS 216.520; 902 KAR 20:300
A physician must provide written approval for each nursing facility admission.	CMS; VA	42 CFR 483.30; 38 CFR 51.150
Upon admission, facilities must provide a CHFS-prepared statement with visiting hours, and visitor rights/duties.	State	KRS 216.545; KRS 216.537; KRS 216.540.
Discharge is allowed only if: facility unable to meet care needs, resident health improvement, safety or health risks to others, nonpayment after notice, or facility closure.	CMS; VA; State	42 CFR 483.15; 38 CFR 51.80; 900 KAR 2:050

Note: VA = Federal Department of Veterans Affairs; CMS = Centers for Medicare and Medicaid Services.
Source: Staff compilation of *Kentucky Acts Of The 2024 Regular Session*, Chapter 175, p 1806; KRS 216B.020; 902 KAR 20:008, 902 KAR 20:310; 38 CFR 51.31, 38 CFR 59.40, 38 CFR 59.80, 42 CFR 483.15, and 42 CFR 483.90.

Beyond statutory and regulatory criteria, veterans' centers have broad discretion over admissions and procedures vary across facilities.

Beyond statutory and regulatory criteria, individual veterans' centers have broad discretion over how they conduct admissions, and procedures vary across facilities. Admissions staff evaluate all applicants to determine that applicants are in need of long-term

care, whether the facility can provide the level of care needed by the applicant, whether the facility can accommodate the applicant's behavioral conditions, and whether there is adequate staffing and capacity to care for the applicant. These evaluations generally include clinical assessments, behavioral health screenings, and reviews of the applicant's ability to be safely accommodated within available units.[169]

After review, admissions staff decide to admit, deny, or defer the applicant. Deferred applicants are placed on an informal waiting list. There is no formal policy defining waiting list procedures; therefore, each center has broad discretion.

Admissions staff then decide to admit, deny, or defer. Individuals that are deferred are placed on an informal waiting list. Placement on a waiting list can occur for a variety of reasons including physical or behavioral health evaluation or capacity limitations. Veterans may also request to be placed on waiting lists in order to queue for future admission. There is no formal regulatory or statutory policy defining admissions or waiting list procedures; therefore, each veterans' center has broad discretion in these matters.[170]

Waiting Lists

Waiting lists are not standardized. Each facility keeps an informal "working list" of veterans who are interested and who may be eligible. Veterans on the list fall into three categories: those who are interested and are submitting paperwork, those whose applications are under review, and those who have been approved and are scheduling an admission date.

Kentucky veterans' centers do not maintain waiting lists in a formal or standardized manner. KDVA reported that instead of maintaining formal waiting lists, each facility keeps an informal "working list" of veterans who are interested in admission and who may be eligible as rooms and circumstances allow. According to KDVA, veterans on these lists generally fall into three categories. The first category, "interested," includes individuals who have expressed a desire to enter a veterans' center and are in the early stages of submitting the required paperwork. The second category, "in review," consists of applicants whose materials are under consideration by the facility's admissions committee. During this stage, staff review all documentation, request updates as needed, meet with the applicant, confirm eligibility, and evaluate whether the facility can safely meet the veteran's clinical and behavioral needs. The third category, "awaiting admission," includes applicants who have completed the review process and are working with staff to schedule an admission date.[171]

In lieu of formal waiting lists, admissions are based on a set of prioritizations when multiple veterans meet admission criteria and seek admission: urgent clinical need, date of application, and readiness for admission.

In lieu of formal waiting lists, when facilities are at capacity, they make admission decisions based upon a set of prioritization principles. According to KDVA, admissions are first prioritized based on urgent clinical need: veterans with more acute medical or care requirements that cannot be safely met in their current living environment may be admitted ahead of others. Among veterans with similar levels of need, priority is then given based on the date the application was completed. Finally, a veteran's readiness for

admission is considered. Applicants who are medically stable, have their financial arrangements in place, and are otherwise prepared to move into the facility may be admitted sooner than those who are still assembling documentation or coordinating personal matters.[172]

Time spent in the admissions process can vary from a few weeks to several months depending on health care needs, room availability, record availability, and individual circumstances.

KDVA reported that the time an applicant spends in the admissions process can vary significantly depending on the veteran's behavioral and physical health care needs, variables at the facility involved, room availability, the time needed to obtain medical or military records, and individual circumstances. The department reported that this can range from a few weeks to several months.[173]

Given the variety of paths and times an application can follow, clear communication with applicants and track of admissions and waitlists are essential.

Given the many pathways and timelines an application can follow from initial inquiry to admission, clear communication with applicants and systematic tracking of admissions decisions and waitlist activity are essential.

The department should also clearly distinguish between active waiting lists for applicants awaiting admission due to capacity constraints or pending clinical evaluations, and interest or processing waiting lists for applicants who have expressed interest in future placement or who have been approved and are preparing for admission. Without clear communication and consistent tracking of these categories, applicants may experience confusion and facilities may reach inconsistent decisions.

Recommendation 4.1

Recommendation 4.1

The Kentucky Department of Veterans' Affairs should promulgate an administrative regulation that defines and establishes procedures for tracking and managing veterans' admissions waiting lists. The regulation should distinguish three types of waiting lists—an active list, to include applicants awaiting admission due to capacity constraints or pending clinical evaluations related to acuity or behavioral health; an interest list, to include individuals who have expressed interest in future placement; and a processing list, to include applicants who have been approved and are preparing for admission. The administrative regulations should be promulgated by October 1, 2026.

Admissions Decision Data For Veterans' Centers

Admissions and waiting list information were inconsistently and irregularly documented, making it difficult to assess long-term care demand and waiting times.

Admissions and waiting list information from the Office of Kentucky Veterans' Centers (OKVC) and each Kentucky veterans' center were requested to determine whether capacity constraints were a significant factor in denial and deferral decisions. However, the data were inconsistently and irregularly documented, both over time within individual facilities and across facilities statewide, making it difficult to assess long-term care demand and waiting times with confidence.

Capacity constraints were not commonly cited as reasons for denial or deferral. The most common reasons were behavioral or physical health needs or withdrawal of the admission request.

Based on the information available, the analysis of facility-level admissions data suggests that capacity constraints were not commonly cited as reasons for denial or deferral. Instead, the most frequently documented reasons for denial or deferral were behavioral or physical health needs that exceeded the facility's capabilities, or the applicant's personal decision to forgo admission.[174]

Variation in admission records may obscure the true reasons for decisions or not capture limitations in capacity.

These findings should be viewed as provisional, however, as variation in the completeness, detail, and terminology of admissions records may obscure the true reasons for admissions decisions or not fully capture limitations related to capacity constraints.

Methodology

Admissions data from 2020 to 2025 were coded into voluntary and involuntary groups. "Voluntary" decisions were those in which applicants were not ready to enter or chose not to enter.

Admissions data from all Kentucky centers from 2020 to 2025 were aggregated into a single dataset and comments were manually coded into standardized variables. Admissions outcomes were grouped into two top-level categories: "voluntary" and "involuntary." "Voluntary" decisions reflected situations in which the applicant was not ready to enter or later chose not to pursue admission. In these cases, the facility did not deny or defer the applicant, though the individual may have remained in a state of deferral or on an informal waiting list.

The coding approach was designed to focus on denials or deferrals driving by factors outside the applicant's control.

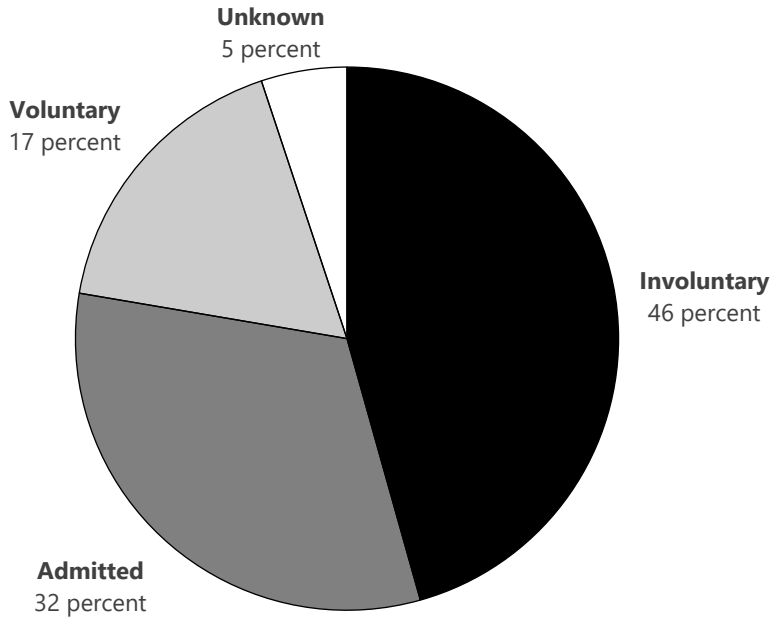
This coding approach was designed to separate "interest" or "processing" deferrals from the broader pool of admissions decisions, allowing the analysis to focus on denials or deferrals driven by factors outside the applicant's control. Applicants who were admitted were placed in a separate category for the same reason.

Voluntary And Involuntary Denial And Deferral

Of the cases analyzed, 46 percent of applications were denied due to involuntary reasons, meaning that the applicant did not decide to forgo admission.

The primary goal of this analysis was to determine whether most denial or deferral decisions during the admissions process were driven by capacity constraints. Admissions outcomes were first categorized as either voluntary or involuntary. Figure 4.A shows that, of the cases analyzed, 17 percent of decisions were voluntary and 46 percent were involuntary. An additional 32 percent of applicants were admitted, while the outcomes of approximately 5 percent of decisions were not documented.[h]

Figure 4.A
Involuntary And Voluntary Admissions Outcomes
For Kentucky Veterans' Centers
2020 To 2025



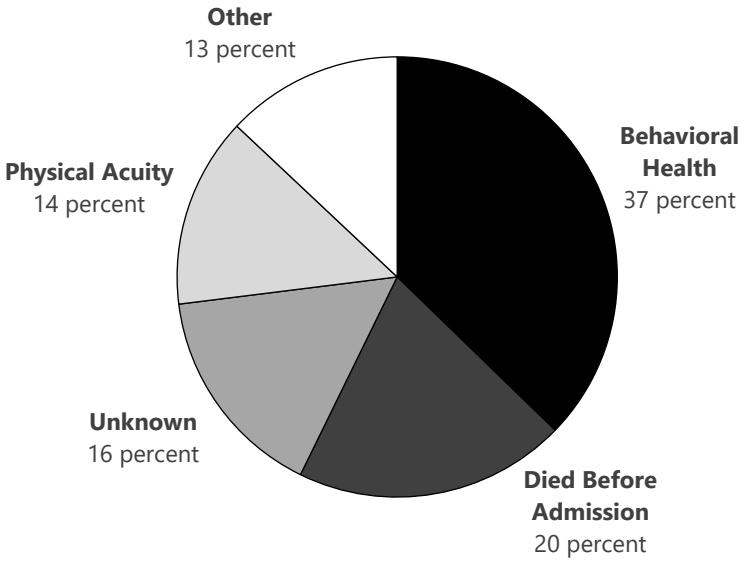
Note: Decisions for 1115 cases were reviwed. The number of duplicate entries is unclear due to the lack of information in records.
Source: Staff analysis of KDVA admission data. Provided to the Legislative Oversight and Investigations Committee on August 18, 2025.

"Involuntary" admission decisions were further categorized into specific subcategories. Where sufficient information was available, staff coded each denial or deferral into one of several reasons,

[h] These percentages reflect the best available information but may not fully capture actual outcomes because of data issues discussed in the following section. They should be interpreted as indicative rather than conclusive.

including cases in which the applicant died before entry, did not meet or exceeded the required level of care, exhibited behavioral issues, was affected by staffing or financial limitations, faced a lack of available space, experienced delays or gaps in medical records; or cases where the reason for the decision was undocumented. Figure 4.B shows the percentages of involuntary deferrals or denials that fell into these subcategories.

Figure 4.B
Reasons For Involuntary Denial Or Deferral
Kentucky Veterans' Centers
2020 To 2025



Note: Decisions for 508 cases with involuntary deferrals or denials were reviwed. The number of duplicate entries is unclear due to the lack of information in records.
Source: LOIC Staff analysis of KDVA Admission Data. Provided to the Legislative Oversight and Investigations Committee on August 18, 2025.

Involuntary Deferrals And Denials

Behavioral health was cited in approximately 37 percent of deferrals or denials. These issues included abusive or aggressive behavior, psychiatric care needs exceeding a facility's capabilities, severe psychiatric instability, active substance use disorder, wandering or elopement risk, and medication noncompliance.

Behavioral Health. Despite limitations in the underlying data, Figure 4.B shows that some trends did emerge. Behavioral health was frequently documented as a reason for an involuntary admission decision across all facilities and resulted in approximately 37 percent of deferrals or denials. This category is inherently broad and was interpreted broadly by admissions staff. Behavioral health-related denials or deferrals can include abusive or aggressive behavior, psychiatric care needs exceeding a facility's capabilities, severe psychiatric instability, active

substance use disorder, wandering or elopement risk, and medication noncompliance.

The documentation of and justification of a behavioral-health denial or deferral varied across facilities.

Differences in how facilities and admissions staff interpreted and recorded these decisions further contributed to how broadly the category is applied. Some entries described behavioral-health decisions only as "unable to meet psychiatric needs," without elaboration. Others used the term "acuity," which is typically reserved for physical care needs rather than behavioral health. Many entries were coded simply as "psychiatric issue" or "behavioral issues." As a result, what constituted a behavioral health-related denial or deferral and how it was documented, varied across facilities.

Regardless of data limitations or documentation consistency, it is clear that many denials and deferrals at Kentucky veterans' centers are the result of applicant behavioral health needs that the facilities cannot accommodate. Most facilities do not have the infrastructure or staff to handle those who may pose a danger to themselves, other residents, or staff. Even facilities which have secure units for residents with behavioral problems often have limited space in that section of the facility and limited staff with the training to care for the residents.

Physical acuity, the resident's physical health care needs, account for 14 percent of all recorded decisions.

Physical Acuity. The second most frequently cited reason for involuntary denials or deferrals across Kentucky veterans' centers was physical acuity, which represents a resident's physical health care needs. Based on the admissions decision data reviewed, physical acuity accounted for approximately 14 percent of all recorded decisions.

Physical acuity was also documented differently across facilities and staff.

However, interpreting this category is complicated by inconsistent terminology and coding practices across facilities and admissions staff. In some instances, admissions teams used "does not meet level of care" to describe applicants whose needs were too low to warrant placement in a long-term care setting. In other cases, the same or similar wording was used to indicate that an applicant's medical needs were too intensive for the facility to safely accommodate. Conversely, other entries explicitly described the applicant's "care needs exceeding facility capabilities," even though the underlying circumstances may have been similar.[175]

The variation reflects the complexity of acuity and the lack of standardized guidance.

These variations reflect both the complexity of resident acuity and the lack of standardized guidance for documenting admissions outcomes. Physical acuity issues can include a broad range of clinical scenarios: extensive wound care, complex medication

regimens, ventilator or dialysis dependence, or other intensive medical interventions that exceed the staffing model or clinical equipment available at a veterans' facility.[176]

Physical acuity plays a central role in determining admissions. Veterans' centers are structured, staffed, and regulated to care for those with sub-acute and long-term custodial care, not intensive or hospital-level care.

Despite inconsistencies in how admissions staff document acuity-related decisions, an underlying pattern is clear: physical acuity plays a central role in determining who can be safely admitted. This reflects the design of the system itself. Kentucky veterans' centers are structured, staffed, and federally regulated to care primarily for residents with sub-acute and long-term custodial needs, not those requiring intensive or hospital-level care. As a result, applicants with care needs that exceed the facilities' clinical capabilities are both appropriately and necessarily deferred or denied admission.[177]

Capacity limits were mentioned in 28 cases from the 533 reviewed.

Capacity Constraints. Analysis of admissions decisions indicates that capacity limitations do not appear to be a primary driver of denials or deferrals at Kentucky veterans' centers. Among the 533 recorded admissions outcomes, only a small fraction were listed as due to capacity limits with only 28 clearly documented examples across all facilities between 2020 and 2025. The admission logs suggest that admissions decisions are being driven primarily by applicant-level clinical considerations rather than by the availability of beds.

In 20 percent of cases, applicants died before a decision was finalized. Another 16 percent of cases lacked sufficient documentation to determine the underlying reason.

Other Categories. In addition to behavioral health and physical acuity, several other categories were represented in the data. Twenty percent of applicants died while deferred or before an admissions determination was finalized, and another 16 percent of decisions lacked sufficient documentation to determine the underlying reason for denial or deferral. The proportion of applicants who died during the admissions or deferral process may signal potential issues with the timeliness of admissions decisions or the length of time applicants remain deferred before a final determination is made. However, due to the inconsistent quality of the underlying data, it is not possible to confidently draw meaningful conclusions.

The large share of insufficiently documented or unclear admission decisions underscores the need for improved data collection and standardized documentation.

The large share of insufficiently documented or unclear admissions decisions underscores the need for improved data collection and standardized documentation processes at Kentucky veterans' centers and OKVC. Without clear, standardized recording of reasons for denial or deferral, it is difficult to assess unmet need, identify bottlenecks, or determine whether admissions decisions are being made consistently and equitably across facilities.

The Impact Of Acuity And Behavioral Health On Veterans' Centers

Patient Acuity

The veterans that can be admitted varies across centers. Facilities with secured units can admit veterans with higher levels of behavioral health need. Facilities with higher-acuity residents need more intensive care and more staff time.

The veterans a facility can admit varies across centers and can change over time. Facilities with secured units are able to admit veterans with higher levels of behavioral health need, while facilities without such units cannot safely accommodate these residents. Admission decisions also depend on each facility's ability to manage different levels of physical acuity based on its current case-mix index, which is a measure of the average acuity of the residents in a facility. Higher-acuity residents need more intensive care.[178] When a facility's overall acuity is high staff must spend more time per resident which increases staff workload and limits the number of residents a facility can safely serve at one time.[179]

KDVA reports that physical health care needs have risen for many years. Veterans are entering later in their health trajectory.

KDVA reports that residents' physical health care needs have steadily risen for many years, creating a more clinically complex resident population and placing growing demands on staffing, facility resources, and operational capacity. While each facility serves residents across a range of medical conditions and levels of functional independence, KDVA emphasized that veterans are entering long-term care later in their health trajectory, often with multiple chronic illnesses, advanced disease progression, and higher levels of dependency than in prior years.[180]

This shift has fundamentally changed the nature of care delivered in the system. KDVA reports that conditions routinely managed at the centers now include diabetes with complications, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, renal failure or end-stage kidney disease, and neurological disorders such as Parkinson's disease and stroke. KDVA attributes some of this shift to the fact that many veterans now remain in the community far longer than in previous years, supported by outpatient services or family care until their conditions become unmanageable. As a result, residents are increasingly admitted to veterans' centers at a much later stage in their disease progression.

Caring for more medically complex residents requires more time, training, planning, need for specialized equipment, and greater use of supplies, therapies, and medical transport.

The increase in physical acuity has major operational effects. KDVA reported that caring for more medically complex residents requires more nursing time, specialized training, and frequent interdisciplinary care planning. Facilities must also coordinate

more complex medication regimens, pain management, wound care, and heightened monitoring of chronic conditions. Higher acuity also increases the need for specialized equipment, more medical transports, and greater use of supplies and therapies.[181]

Behavioral Health

All four operating centers care for veterans with a wide range of mental and behavioral health conditions.

Kentucky Veterans' Centers are serving a resident population whose behavioral health care needs have grown substantially in both prevalence and complexity over the past decade. According to KDVA, all four operating centers now care for veterans with a wide range of mental and behavioral health conditions, including PTSD, depression, anxiety, schizophrenia, substance use disorders, and progressive dementia, with needs that often require intensive, interdisciplinary management. This trend is being driven by multiple factors, including an aging veteran population with significant comorbid medical conditions, delayed entry into long-term care, increased survival following serious illness or injury, and persistent gaps in community-based behavioral health services. As a result, behavioral health support has become a core component of daily clinical operations within the Kentucky veterans' centers.[182]

Behavioral health issues have increased steadily for many years. Cognitive impairment is more common. Centers continue to admin veterans whose needs meet eligibility requirements but are near the upper bounds of what they are designed to manage.

Challenges Related To Behavioral Health Care. KDVA reports that, like acuity, behavioral health issues have increased steadily for many years. Antianxiety, antidepressant, and antipsychotic medication use has risen, reflecting higher levels of depression, anxiety, PTSD, and other psychiatric conditions among incoming residents. Cognitive impairment is also more common; many residents present with moderate to severe dementia, Alzheimer's disease, or neurocognitive disorders that manifest in wandering, agitation, or other challenging behaviors. Numerous veterans now require continual supervision, trauma-informed care strategies, and frequent interdisciplinary team interventions. At the same time, centers continue to admit veterans whose physical and behavioral needs meet eligibility requirements but lie near the upper bounds of what a long-term care environment is designed to manage, which increases the operational burden on nursing and behavioral health staff. [183]

KDVA reports that this burden on staff is significant and affects all aspects of daily operations. Behavioral health care delivered using an interdisciplinary model that includes psychiatric nurse practitioners, psychologists, social workers, nursing staff, and primary medical providers. Non-pharmacological interventions are emphasized as first-line approaches in accordance with long-term

care regulations, meaning that frontline staff must devote significant time to monitoring, de-escalation, environmental modification, and engagement strategies before medication is considered. Clinical teams routinely conduct behavioral assessments, hold special care plan meetings, hire behavioral health aides when appropriate, and coordinate care closely with families. Trauma-informed care is widely embedded in daily practice, especially given the high prevalence of PTSD, military trauma histories, and overlapping cognitive decline; therefore, staff receive ongoing training in behavioral management, dementia care, de-escalation, and mental health first aid. [184]

KDVA reports substantial systemwide challenges in meeting behavioral health needs.

Despite these efforts, KDVA reports substantial systemwide challenges in meeting behavioral health needs. Veterans' Centers frequently struggle to admit or retain residents with severe or unstable psychiatric or behavioral presentations, particularly when aggression or unpredictability poses safety risks to other residents and staff. Moreover, facilities simply cannot admit residents who are acutely mentally ill, actively disruptive, or a danger to self or others, as they are not equipped to provide that level of care. [185]

Admitted residents' behavioral needs can escalate beyond the capabilities of centers. There are barriers in securing placement in external geriatric psychiatric units. These barriers result in situations where residents' needs exceed the scope of centers, creating safety concerns and increased staff burden.

In addition, admitted residents' behavioral needs can often escalate beyond the capabilities of the centers. When this happens, facilities face serious barriers in securing placement in external geriatric psychiatric units or specialized behavioral health facilities because those resources are limited statewide. KDVA notes that, even when it is institutionally warranted and necessary, it is almost impossible from a regulatory standpoint to execute an involuntary discharge because of state and federal laws protecting long-term care residents. Even when a transfer is clinically warranted, appropriate receiving facilities often do not exist or are unwilling to accept a resident. This creates situations where veterans' centers must continue managing residents whose care needs exceed their licensed scope, which creates safety concerns and increases staff burden. [186]

Across all four Kentucky veterans' centers, behavioral health needs have become a defining operational and clinical challenge. Meeting these needs requires substantial staffing resources, specialized training, and access to external psychiatric services that are not consistently available in Kentucky. Although the centers are providing increasingly complex behavioral health care, the system faces structural limitations in admitting or managing veterans whose psychiatric or behavioral conditions exceed their capabilities. These limitations directly affect admissions decisions, staffing challenges, resident safety, and overall system capacity.[187]

While secured behavioral health units increase centers' ability to manage residents with higher acuity needs, the secure unit at RVC is unavailable due to an HVAC renovation. The Bowling Green center was not designed with a secured unit and its behavioral health capacity will be permanently limited.

Accommodating Behavioral Health Needs. KDVA and veterans' centers administrators described each facility's ability to accommodate varying levels of behavioral health needs, as well as the behavioral health challenges currently affecting their operations. Table 4.2 summarizes these capabilities and challenges for all five Kentucky veterans' centers. Secured behavioral health units at most facilities substantially increase their capacity to manage residents with higher-acuity behavioral health needs. However, the secure unit at Radcliff Veterans Center (RVC) is unavailable due to an HVAC renovation, which limits the facility's ability to manage higher-risk behavioral residents. The Bowling Green Veterans Center was not designed with a secured unit, and its behavioral health capacity will remain permanently limited as a result.[188]

Table 4.2
Behavioral Health Capabilities And Challenges
Reported By Administrators Of Kentucky Veterans' Centers

Facility Name	Behavioral Health Capabilities	Reported Challenges
Thomson-Hood Veterans Center	• Full range, mild to sub-acute • Secure unit • Single-occupancy rooms • Specialized behavioral staff • Staffing constraints	• Increased strain on staff. • Aging infrastructure complicates dementia and behavioral-health management. • Approaching a decision point on whether to maintain single-occupancy rooms.
Eastern Kentucky Veterans Center	• Full range, mild to sub-acute • Secure unit • Double-occupancy rooms • Specialized behavioral staff • No staffing constraints	• Rising behavioral acuity is increasing clinical demands. • Double-occupancy rooms complicate management of behavioral triggers. • Limited statewide geriatric-psych capacity denies residents needed higher-level care.
Western Kentucky Veterans Center	• Full range, mild to sub-acute • Secure unit • Mixed-occupancy rooms • Specialized behavioral staff • Staffing constraints	• Staffing shortages make behavioral health care more difficult as those residents require more care and attention. • Behavioral health care demands of residents negatively impacts staffing retention.
Radcliff Veterans Center	• Limited range • No secure unit • Single-occupancy rooms • Specialized behavioral staff • No staffing constraints	• High behavioral acuity relative to other Kentucky veterans' centers. • Currently lacks a secured unit due to the HVAC renovation. • Significant staff behavioral health training burden.
Bowling Green Veterans Center	• Limited range • No secure unit • Single-occupancy rooms	• Lack of a secured unit will limit acceptance of high-risk behavioral residents.

Source: LOIC staff compiled information from KDVA data and information requests. Provided to LOIC staff Aug. 18, 2025.

Single- or double-occupancy room configurations significantly influences a veterans center's ability to accommodate behavioral needs.

Another key facility characteristic that significantly influences a veterans' center's ability to manage and accommodate behavioral health needs is whether resident rooms are configured as single-occupancy or double-occupancy. Room configuration affects not only resident safety and quality of life, but also the clinical feasibility of managing behavioral symptoms, particularly those associated with dementia, PTSD, and serious mental illness.[189]

Single-occupancy rooms allow more effective intervention during behavioral episodes and may support trauma-informed care or environmental adjustments.

Single-occupancy rooms provide greater flexibility and clinical control in managing behavioral health concerns. Private rooms allow staff to intervene more effectively during episodes of agitation or confusion, reduce environmental triggers that may worsen behavioral symptoms, and prevent conflicts between roommates.[190] For residents with PTSD or trauma histories, private rooms support trauma-informed care by offering personal space, reducing overstimulation, and minimizing intrusive noise and activity. Single rooms also allow staff to tailor the environment, such as lighting, sensory stimulation, and routines, to individual behavioral needs.[191]

By contrast, double-occupancy rooms create environmental challenges that can exacerbate behavioral symptoms and increase the risk of behavioral conflicts due to roommate incompatibility, personal-space conflicts, sleep disturbances, noise, and competing routines. Table 4.2 lists the facilities within the Kentucky veterans' center system that use single-occupancy rooms.[192]

Recommendation 4.2

Recommendation 4.2

The Kentucky Department of Veterans' Affairs should report to the General Assembly on the scope and impact of the behavioral health challenges facing Kentucky veterans and Kentucky veterans' centers. The report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026.

Recommendation 4.3

Recommendation 4.3

In its next budget request, the Kentucky Department of Veterans' Affairs should request funding for a study to investigate solutions to care for veterans with behavioral health challenges.

Inconsistent And Non-Standardized Data Collection And Documentation

While KDVA provided admissions data from 2020 to 2025, the information was inconsistent, incomplete, and unreliable. Staff could not fully determine whether admission delays were caused by capacity constraints.

While KDVA provided admissions-related data from 2020 to 2025, the information was inconsistent, incomplete, and methodologically unreliable. As a result, staff could not fully determine whether admission delays were caused by capacity constraints. Data collection practices varied significantly across facilities and over time but improved over time. For example, WKVC began reporting only the most recent interaction with an applicant in earlier years but documented multiple interactions per applicant by 2025. Across all facilities, some early years were missing entirely, and missing years differed by facility. Centers also differed in whether they provided explanatory comments for deferrals or denials, with some offering detailed rationales and others providing none.

Recorded reasons for deferral or denial varied significantly, with some centers routinely documenting layered causes for a decision. Data was structured differently across facilities and each center used its own methodology for recording decisions.

In addition, the number of recorded reasons for deferral or denial per applicant also varied significantly with some centers routinely documenting layered causes for a decision. For example, acuity, behavioral issues, and missing records might contribute to a decision, while others listed only a single reason or none at all. Additionally, data was structured differently across facilities. Each center used its own methodology for recording decisions which made cross-facility comparisons difficult. This variability made it difficult to determine whether trends reflected actual differences across centers or merely differences in documentation practices.

As an example, THVC had no entries indicating an applicant died while every other facility did. RVC and WKVC logged delays in securing medical records, but the other facilities did not.

Particularly problematic are documenting procedures that were consistently different across facilities. For example, while most centers documented if an applicant died before entry, THVC logs made no mention of applicant deaths. RVC and WKVC logs noted delays in securing medical records as a barrier to admission, but THVC and EKVC recorded no instances. Some facilities used "unable to meet level of care" broadly to capture multiple underlying issues, including behavioral concerns, high physical acuity, or a facility's lack of specialized services, while other facilities separated these into specific denial reasons. These fundamentally different approaches made any cross-facility comparisons inconclusive.

In many cases, it was impossible to distinguish between applicants who died before admission due to voluntary decisions to delay from applicants who experienced long delays or prolonged evaluation periods.

The lack of standardized definitions and incomplete documentation frustrated the process of drawing potentially important conclusions. For example, in many cases staff was unable to distinguish between applicants who died before they were admitted due to voluntary decisions to delay admission from applicants who

experienced involuntary delays due to long periods of deferral or prolonged evaluation periods. With better information staff at OKVC and veteran center administration would be better positioned to know if an applicant's death prior to admission reflected unfortunate timing, regrettable but unavoidable due diligence in evaluation, or potentially avoidable processing delays.

In some years, as much as 20 percent of entries lacked sufficient information to interpret the reason for deferral or denial.

Persistent data quality problems included missing identifiers, duplicate entries, missing documentation, the absence of provided reasons, and conflicting information within the same record. In some years, as much as 20 percent of entries lacked sufficient information to confidently interpret the reason for a deferral or denial. This seriously limits OKVC's and Kentucky veterans' centers administration's ability to draw important conclusions from, and properly communicate the reasons for, admission, deferral, and denial decisions.

These admission logs were not originally designed to serve as sources for internal analytics or policy analysis. The data shows meaningful improvement over time.

However, these admissions decision logs were not originally designed to serve as systemwide data sources for internal analytics or policy analysis. They were developed for internal operational purposes, primarily to support communication among staff within each facility and assist with daily work. In addition, the data also shows meaningful improvement over time. Facilities increasingly recorded multiple interactions with applicants, provided more detailed explanatory comments, and used more consistent terminology in later years. WKVC's and EKVC's 2025 data, for example, reflects a far more robust and transparent approach to documenting decision points than its earlier logs. Similar improvements can be observed across all centers. This trend indicates that KDVA's data collection practices are moving in the right direction, even though they remain fragmented and non-standardized.

With standardized procedures, detailed documentation, and complete applicant histories, OKVC, veterans center leadership and the legislature could more confidently evaluate admissions practices, understand unmet need, or assess whether delays or decision processes impact veteran access to care.

Recommendation 4.4

Recommendation 4.4

The Kentucky Department of Veterans' Affairs should improve, formalize, and standardize its data collection, management, and analysis practices related to admissions decisions and waitlist management. As part of this effort, the department should develop a standardized, systemwide database that records admissions decisions using consistent evaluation criteria that captures full case histories. The department should centralize this process within the Office of Kentucky Veterans' Centers and report to the Legislative Oversight and Investigations Committee on the progress of this effort by October 1, 2026.

Improving Communication With Applicants And The Legislature

Applicants And Families

Complaints to legislators indicate that some applicants do not fully understand why they are denied or deferred. This disconnect suggests the rationale may not always be communicated in a clear way.

Although admissions logs do not document how facilities communicate decisions to applicants and families, constituent complaints to legislators indicate that some applicants do not fully understand why they are being denied or deferred. In these cases, families appear to assume that the decision is due to a lack of available beds but become frustrated when they see publicly reported occupancy rates that fall below the facility's certified capacity. This disconnect suggests that, even when admissions decisions are clinically appropriate, the rationale may not always be communicated in a way that is clear or easily understood by applicants.

For behavioral and physical acuity-based decisions, it is unclear if applicants and families are receiving enough context for the admissions process because these evaluations are subjective by nature.

Behavioral health and physical acuity-based decisions represent an especially difficult communication challenge. The majority of such outcomes are deferrals rather than denials, typically issued in 90-day intervals. It is unclear if applicants and families are receiving enough context for their admissions process because behavioral and physical health admission evaluations are subjective by nature. Providing additional context surrounding these subjective decisions would be beneficial. Factors such as clearly communicating the facilities limitations, whether improvement is likely to lead to admission, or whether the facility has the capacity, such as a secure behavioral health unit, to meet the applicant's needs.

Confusion may stem from the lack of standardized terms and documentation procedures found in the admission logs.

Part of the confusion may stem from the lack of standardized terminology and documentation procedures found in the review of facility admission decision logs. While each facility must retain operational flexibility, because its ability to accept applicants with specific clinical or behavioral needs depends on its current resident mix, this variability does not necessitate equally variable explanations to applicants. Standardized definitions, categories, and communication templates would allow facilities to apply different operational judgments while still communicating consistent, understandable information.

When a facility reports occupancy, it generally reports certified occupancy without accounting for limitations. This could lead to the appearance of rejection despite available capacity.

Furthermore, when a facility reports its occupancy, it generally reports its overall certified occupancy without accounting for capital projects, model transitions, or available capacity of specialized units such as secure behavioral health units. This could lead to the appearance of an applicant being rejected despite available capacity. Communicating functional capacity in addition to certified capacity will help address this problem.

Recommendation 4.5

Recommendation 4.5

The Kentucky Department of Veterans' Affairs should promulgate an administrative regulation establishing a standardized, systemwide process for communicating admissions decisions across all Kentucky veterans' centers. This regulation should specify the information that must be communicated to applicants in each case and ensure that facilities provide this information in a consistent manner. The administrative regulation should be promulgated by October 1, 2026.

Policymakers

Communication between KDVA and the General Assembly has been hindered by inconsistencies in information conveyed and weaknesses in underlying data.

Clear, accurate information about capacity, occupancy, admissions activity, staffing, and veteran demand for long-term care is essential for effective oversight and policymaking. Communication between KDVA and the General Assembly has been hindered in two primary ways: by inconsistencies in what information the department conveys and how it is presented, and by weaknesses in the underlying data collected by the department itself.

Legislators have not been provided the context of single-occupancy room transitions, unavailable beds, and ongoing capital projects.

With respect to occupancy and capacity, legislators have expressed concerns that facility occupancy is too low, but have not been provided with the proper context of single-occupancy room transitions, decertified or unavailable beds, and ongoing capital

projects that reduce functional capacity. Legislators have also raised concerns about lost revenue associated with lower occupancy, despite the fact that current policy and budgeting result in increases to occupancy also increasing operational costs. [193] At the same time, admissions decisions and waiting list information, key indicators of unmet need, access barriers, and system performance, have not been systematically tracked or reported in a manner that supports reliable decision-making.

These gaps make it difficult for policymakers to accurately assess the condition of the veterans' center system, understand the drivers of unmet need, or evaluate the effects of population trends, operational practices, or funding decisions. Providing high-quality, consistent, and timely data to the General Assembly is essential for ensuring that Kentucky can meet its long-term care obligations to veterans. Given that there has been miscommunication regarding occupancy and capacity, that admissions decision data has historically been inadequately tracked, and that waiting lists have not been consistently maintained or managed, it is recommended that KDVA provide the legislature with annual reports on multiple veterans' centers metrics.

Recommendation 4.6

Recommendation 4.6

The Kentucky Department of Veterans' Affairs should provide the General Assembly with an annual report on the status of the Kentucky veterans' center system. The report should include data on admissions, denials, deferrals, waiting lists, occupancy, certified and functional capacity, and the status of filled staffing positions. This report should be provided to the Legislative Oversight and Investigations Committee; the Interim Joint Committee on Veterans, Military Affairs, and Public Protection; and the Legislative Research Commission by October 1, 2026. It should be provided by the same date annually thereafter.

Matter For Legislative Consideration 4.A

Matter For Legislative Consideration 4.A

The General Assembly may wish to consider making the annual reporting of data and information related to the admissions, denials, deferrals, waiting lists, occupancy, capacity, and staffing of Kentucky Veterans' Centers statutorily mandated. To prevent this report from being produced after the General Assembly's concerns are resolved, the General Assembly may wish to include a sunset provision.

Establishing An Application Decision Appeals Process

Creating a formal application appeals process would improve communication between veterans' centers and applicants. Currently, admissions determinations are made by facility staff. Interviews revealed significant variation in reconsideration request reviews.

Creating a formal application decision appeals process would improve communication between Kentucky veterans' centers and provide applicants with more information regarding their deferrals or denials. The centers do not currently have a standardized or formal process for veterans or their families to appeal admissions decisions. Instead, admissions determinations are made by facility-level staff based on clinical criteria, medical readiness, and whether the center can safely meet the applicant's needs. Interviews with facility administrators revealed significant variation in how reconsideration requests are handled.

At EKVC, reconsiderations may go to an interdisciplinary team. At WKVC, admission denials are generally considered final. At THVC, there was no formal appeal or review pathway.

Each facility reported using its own informal approach. At EKVC, administrators stated that if a veteran or family asks for reconsideration, the administrator may convene the Interdisciplinary Team to review the case. WKVC staff reported that admissions denials are generally considered final, but noted that their deferral process serves as a quasi-appeals mechanism because applicants are periodically reevaluated. At THVC, staff indicated they were not aware of any formal appeal or review pathway, though they will reassess updated medical or personal information when requested. The Office of Kentucky Veterans' Centers reported that some applicants in the past have contacted the office directly to request review, prompting ad hoc follow-up by KDVA leadership.

KDVA leadership has limited visibility into whether similar cases are treated consistently across facilities or whether operational constraints are influencing decisions that should be driven by clinical criteria.

These inconsistencies highlight the lack of a structured system for reviewing admissions decisions. A review of admissions documentation further showed variation in how outcomes are recorded, how reasons for denial are documented, and how applicants are informed of decisions. Without standard templates, required documentation elements, or a clearly defined process for applicants to request reconsideration, KDVA leadership has limited visibility into whether similar cases are treated consistently across facilities or whether operational constraints are influencing decisions that should principally be driven by clinical criteria.

A formal appeals process is an established best practice in long-term care. Federal regulations and CMS guidance emphasize residents must have access to grievance and appeal mechanisms for high-stakes decisions.

A formal appeals process is a well-established best practice in long-term care, giving applicants a clear avenue to raise concerns, submit additional information, and receive impartial review. Federal long-term care regulations and CMS guidance already emphasize that residents must have access to formal grievance and appeal mechanisms for high-stakes facility decisions, including decisions to transfer or discharge a resident.[194] These requirements

reflect the expectation that nursing facilities provide transparent, structured processes to challenge decisions that materially affect residents. Establishing a formal admissions decision appeals process for Kentucky veterans' centers would be consistent with these expectations and would extend similar safeguards to veterans at the point of admission.

Documentation and tracking of appeals would allow KDVA to identify trends, determine if similar cases are treated consistently, and address systemic issues.

A standardized appeals mechanism would also improve KDVA's oversight. Consistent documentation and centralized tracking of appeals would allow KDVA to identify trends in denials, determine whether similar cases are treated consistently across facilities, and address systemic issues such as behavioral health needs, rising acuity, or functional capacity constraints. Implementing a formal review pathway would also better align Kentucky with practices in other state veterans home systems that maintain structured reconsideration or centralized admissions review processes.[195]

Recommendation 4.7

Recommendation 4.7

The Kentucky Department of Veterans' Affairs should establish a formal appeals process for veterans who have been denied admission or deferred for longer than 90 days. The specific structure and administrative procedures for the process should be developed at the discretion of the Kentucky Department of Veterans' Affairs and the Office of Kentucky Veterans' Centers. However, the process should, at a minimum, create a single, centralized mechanism through which any applicant may appeal a denial or an extended deferral; and include participation from facility administrators and the executive director of the Office of Kentucky Veterans' Centers. The department should promulgate the appeals process in administrative regulation by October 1, 2026.

Kentucky And National Veteran Population Trends

It is not possible to assess demand for veterans' centers based on facility information because data were recorded inconsistently. Instead, broader trends in Kentucky's veteran population were used.

It is not possible to reliably assess overall demand for Kentucky's veterans' centers based solely on facility-reported information because data on admissions deferrals and denials were recorded inconsistently across facilities and over time. To provide additional context, LOIC staff examined broader trends in Kentucky's veteran population, particularly demographic and socioeconomic factors associated with higher likelihood of seeking placement in a state veterans home, including age, poverty status, and disability prevalence.

Overall, Kentucky's veteran population has been declining annually, mirroring national trends. From 2010 to 2024, Kentucky's veteran population has declined by 29 percent, slightly above the national average of a 28 percent decline.[196] No state has increased its veteran population in that time period. Table 4.3 has a comparison of the two states with the largest change and the two states with the smallest change from 2010 to 2024.

Table 4.3
Percentage Change In Veteran Population
2010 To 2024

State	Percent Change
Idaho	-10%
Texas	-12
Kentucky	**-29**
Connecticut	-43
New Jersey	-45
National average	-28%

Note: The table compares Kentucky to the two states with the smallest decline in veteran population and the two states with the largest decline.
Source: United States. Census Bureau. "2010: ACS 1-Year Estimates Detailed Tables. Age By Veteran Status By Poverty Status In The Past 12 Months By Disability Status For The Civilian Population 18 Years And Over." nd. Data.Census.Gov; United States. Census Bureau. "2024: ACS 1-Year Estimates Detailed Tables. Age By Veteran Status By Poverty Status In the Past 12 Months By Disability Status For The Civilian Population 18 Years And Over." nd. Data.Census.Gov.

Examining Kentucky's population specifically, Table 4.4 shows that between 2010 to 2024, the total number of veterans residing in Kentucky decreased from approximately 307,800 to 217,300, a reduction of 29 percent. This decline is consistent with national demographic trends, driven largely by aging cohorts, lower enlistment rates following major conflicts, and natural mortality among older veterans.[197] The table also shows the number of Kentucky veterans with characteristics that make them likely candidates for long-term care at a Kentucky veterans' center: being over the age of 65, low-income, and having a disability.

Table 4.4
Trends In Kentucky's Veteran Population And The Kentucky Veteran Center Representative Population 2010 To 2024

Year	Veteran Population	Veterans Over 65	Veterans In Poverty	Veterans With Disability	Veteran Center Representative Population	Representative Population As A Percentage Of Veteran Population
2010	307,801	118,093	25,635	93,375	4,057	1.32%
2011	306,381	121,127	25,060	95,131	4,307	1.41
2012	309,098	128,790	26,901	92,859	4,761	1.54
2013	286,698	128,747	26,714	96,165	4,935	1.72
2014	273,502	123,735	24,160	92,619	4,567	1.67
2015	275,721	129,479	22,169	90,655	3,898	1.41
2016	267,176	131,455	21,540	90,868	3,727	1.39
2017	258,559	125,876	23,332	85,452	3,550	1.37
2018	256,029	122,167	19,886	83,213	3,416	1.33
2019	245,744	122,750	21,701	84,378	5,132	2.09
2020	252,819	123,504	21,099	86,564	4,022	1.59
2021	234,273	113,434	19,978	83,184	4,217	1.80
2022	228,361	106,347	19,587	79,960	4,741	2.08
2023	212,935	103,787	17,330	76,981	3,919	1.84
2024	217,332	99,719	20,135	74,594	5,052	2.32
% Change	-29%	-16%	-21%	-20%	25%	76%

Source: Staff compiled data from the United States Census Berea's American Community Survey. "Age By Veteran Status By Poverty Status By Disability Status".

Although Kentucky's overall veteran population has decreased, the number of older, low-income veterans with a disability has increased.

Although Kentucky's total veteran population has declined substantially, the composition of that population has shifted in ways that are critically important for understanding long-term care needs in the commonwealth. The data indicate that Kentucky's veteran population is becoming older, more economically vulnerable, and more medically complex, even as the overall number of veterans declines.

First, while the absolute number of veterans aged 65 and older decreased from approximately 118,000 to 99,700 (a 16 percent decline), this reduction occurred at roughly half the rate of the decline in the total veteran population. As a result, older adults now represent a much larger share of all Kentucky veterans than they did a decade ago. Second, the number of veterans living below the federal poverty line declined from 25,635 to 20,135 (21 percent), and the number of veterans with a disability declined from 93,375 to 74,594 (20 percent). However, these declines are far smaller than the overall population decline, meaning that economically vulnerable and disabled veterans now make up a larger proportion of the remaining veteran population.

Finally, the specific population most likely to require state-supported long-term care, veterans who are aged 65 or older, below the poverty line, and have a disability, has grown significantly over the period. This group of Kentucky veterans is the group that most represents the type of veterans that are likely to need long-term care at a Kentucky veterans center. This group increased from 4,057 in 2010 to 5,052 in 2024, a rise of 25 percent. As a share of the total veteran population, this high-risk, high-need group increased from 1.32 percent to 2.32 percent, a 76 percent increase. This means the Kentucky veterans' center system is serving a veteran population that is increasingly concentrated with individuals who are older, poorer, and more medically complex.

This demographic reality has direct implications for the Kentucky veteran system capacity. Kentucky's current certified capacity of 681 beds and functional capacity of 446 beds are both significantly below the size of the 5,052-member "Kentucky veteran center representative population." Even if only a fraction of these high-need veterans ultimately seek placement, the population of veterans who meet the strongest predictors of long-term care reliance exceeds both certified and functional bed capacity.

Based on the demographic trends, veterans' centers will likely face higher acuity demands and potentially increased overall demand. However, it is unclear what percentage of the total likely veteran population will seek long-term care placement.

Together, these trends suggest that Kentucky veterans' centers will almost certainly continue to face higher acuity demands and may also experience increased overall demand. It is important to acknowledge, however, that it is unknown what portion of the "Kentucky veteran center representative population" is actively seeking long-term care placement. This uncertainty underscores that KDVA and individual centers should redouble their efforts to track, centralize, manage and standardize admission and wait list data. If admissions data reflects these demographic trends, the commonwealth's increasingly older, more disabled, and more economically vulnerable veteran population will have significant implications for capacity planning, staffing requirements, facility modernization, and future capital investments.

Kentucky Veterans' Centers Quality Of Care Has Been Consistently High

Kentucky veterans' centers have had consistently high quality-of-care ratings. With the exception of WKVC, all quality-of-care ratings are higher than national and state averages.

Ultimately, the most important metric by which a long-term care facility, or a state veterans care system, can be judged is quality of care. Despite the challenges they have faced, Kentucky veterans' centers have had consistently high quality-of-care ratings. The previous chapter discussed that Kentucky's total cost of care exceeds the VA prevailing rate. The quality metrics presented in

the following section show what the commonwealth is receiving for that higher investment. With the exception of WKVC, all of Kentucky veterans' centers have quality-of-care ratings that are higher than national and state averages.

CMS Quality-Of-Care Metrics

CMS employs quality measures to assess nursing home care. Table 4.5 displays these metrics and compares Kentucky's quality-of-care evaluations to other long-term care facilities the state and nationwide. This includes all long-term care facilities including private facilities.

Table 4.5
Centers For Medicare And Medicaid
Quality-Of-Care Metrics
2025

Metric	EKVC	RVC	THVC	WKVC	State Average	National Average
Overall score, 1 to 5	4	4	5	2	3	3
Number of						
emergency visits	1.44	1.68	0.57	1.78	2.18	1.78
hospital days	1.26	0.80	0.43	1.43	1.91	1.83
Percent of residents						
whose independent movement worsened	12.0%	14.5%	18.3%	22.9%	22.1%	19.4%
with catheter	0.3	0.6	0.2	1.0	0.9	1.2
with major injury from falls	3.9	4.0	5.8	4.0	3.8	3.3
with increase in help for daily activities	13.8	17.1	15.1	22.8	18.2	16.2
with pressure ulcers	8.0	2.9	2.6	13.5	6.2	5.4
with antipsychotic drugs	25.1	21.6	18.1	18.4	15.9	14.5
with urinary tract infections	1.2	3.1	3.7	1.7	2.1	1.8
who needed and got a flu shot	98.8	98.4	100.0	98.6	96.2	95.3
who needed and got pneumonia vaccine	100.0	98.7	98.3	98.3	93.5	93.4
of residents physically restrained	0.0	0.0	0.0	0.0	0.2	0.1
with worsened bowel or bladder incontinence	11.3	31.3	26.1	24.0	21.2	20.7
who lose too much weight	5.0	7.4	2.0	2.4	7.0	5.5
with depression symptoms	1.1	1.0	1.0	2.9	13.2	10.3
with antianxiety/hypnotic medication	40.2	5.4	14.5	8.8	29.7	19.9

Note: EKVC = Eastern Kentucky Veterans Center; RVC = Radcliff Veterans Center; THVC = Thomson-Hood Veterans Center; WKVC = Western Kentucky Veterans Center.
Source: United States. Centers for Medicare and Medicaid Services. "Provider Data Catalog." Web. Accessed November 20, 2025.

THVC received a 5 out of 5 overall score. EKVC and RVC both received a 4 out of 5 score. WKVC received a 2 out of 5 score.

Quality-of-care indicators across Kentucky veterans' centers demonstrate meaningful variation among facilities, but overall performance is generally comparable to or better than state and national averages in many core clinical areas. THVC shows the strongest overall performance, receiving a 5-out-of-5 overall quality score, while EKVC and RVC score slightly below at 4. WKVC lags behind the others, with an overall score of 2, reflecting higher rates of certain adverse outcomes.

Kentucky veterans' centers perform well on vaccine coverage, physical restraints, and depressive symptoms.

Across several resident-health measures, Kentucky veterans' centers outperform national norms. All four facilities maintain exceptionally high vaccination rates, with flu and pneumonia vaccine coverage consistently above 98 percent—substantially higher than the national averages of 95.3 and 93.4 percent, respectively. Rates of physical restraints are also at or near zero statewide, aligning with best-practice standards and outperforming national benchmarks. Similarly, the prevalence of depressive symptoms is notably low across facilities, particularly at EKVC, RADC, and THVC, all of which report rates far below the national average of 10.3 percent.

THVC has above average rates of falls with major injuries but has low rates of hospitalizations and emergency department visits.

Rates of falls with major injury show mixed results. EKVC and WKVC are close to national averages, while THVC reports the highest rate (6 percent), slightly above both state and national benchmarks. Hospitalizations and emergency department visits per 1,000 resident days are lowest at THVC and substantially below national norms. WKVC's hospitalization rates are closer to, but still generally below, state and national averages.

While Kentucky's facilities generally perform well, use of antipsychotic drugs at all facilities is higher than state and national averages. This trend matches statements from admissions data and interviews.

Overall, Kentucky veterans' centers perform well on most metrics, often exceeding state and national benchmarks. THVC and RADC show consistently strong outcomes. WKVC shows the weakest performance among Kentucky facilities, with higher rates of functional decline relative to other facilities. EKVC scores well on most measures, but it uses antipsychotic and antianxiety medications more often than other facilities. Use of antipsychotic drugs at all facilities is higher than state and national averages. This corroborates evidence from admissions data and comments during staff interviews that behavioral health issues have become a major concern for Kentucky veterans' centers.

However, quality measures are influenced by both the care at the facility and the health of residents when they arrive at the facility.

However, quality measures that rely solely on resident outcome are influenced by both the care that the facility provide and how sick the residents are when they arrive at the facility.[198] If a facility takes residents with higher needs, they may look worse on raw outcome measures even if the care is very good. These measures

are informative but imperfect and need context. For example, EKVC's use of antianxiety medications may be medically necessary for the care of their residents, yet appears as a negative in the CMS metrics. Similarly, THVC's increased number of average falls that result in injury could be attributable to a higher level of acuity among their residents.

CMS data showed that Kentucky veterans' centers had few deficiencies in the most recent three-year inspection cycle.

CMS Care Compare data indicate that Kentucky veterans' centers have had few deficiencies in the most recent three-year inspection cycle. Eastern Kentucky Veterans Center had no complaints filed in the most recent reporting period, and the other centers had limited complaint-related deficiencies, with only a single complaint filed with THVC and two filled at RVC.[199]

Occupancy levels, certified and functional capacity, staffing models, revenue generation, and admissions activity are all meaningful indicators of how a veterans' center system operates. However, each of these metrics is ultimately secondary to the most important question: Are residents receiving safe, high-quality care?

Across the measures that matter most for resident well-being, Kentucky veterans' centers perform strongly. While facility-level variation exists and while facilities face ongoing challenges related to staffing, admissions processes, data collection, modernization, and capacity, the system is delivering high-quality care to a growing number of Kentucky veterans. Ongoing initiatives, such as the transition to single-occupancy rooms, completion of major capital projects currently limiting capacity, the opening of new modern facilities, and recent funding measures that have strengthened staffing at multiple centers, point to the potential for continued progress.

Appendix

Change In Veteran Population
By State
2010 And 2024

State	2010	2024	% Change
Idaho	123,409	111,575	-9.6%
Texas	1,575,275	1,392,671	-11.6
Georgia	687,301	596,482	-13.2
North Carolina	715,514	615,719	-13.9
South Carolina	401,823	341,158	-15.1
Colorado	384,873	324,809	-15.6
Arizona	522,266	436,272	-16.5
Tennessee	481,185	395,251	-17.9
Delaware	72,250	59,068	-18.2
Virginia	731,059	595,152	-18.6
Florida	1,592,773	1,289,934	-19.0
Nevada	227,741	182,432	-19.9
North Dakota	50,996	40,730	-20.1
Montana	93,620	74,496	-20.4
Maryland	421,624	327,481	-22.3
Washington	585,690	448,646	-23.4
Alabama	394,472	294,749	-25.3
Alaska	70,726	52,577	-25.7
South Dakota	67,888	50,070	-26.2
Oklahoma	316,039	229,032	-27.5
Utah	150,032	107,294	-28.5
Hawaii	114,083	81,538	-28.5
New Hampshire	112,634	80,041	-28.9
Kentucky	**307,801**	**217,332**	**-29.4**
Wyoming	51,811	36,458	-29.6
Oregon	325,860	228,792	-29.8
New Mexico	176,856	123,286	-30.3
Missouri	483,433	335,676	-30.6
Kansas	210,583	145,845	-30.7
Mississippi	200,540	137,824	-31.3
Louisiana	303,951	208,646	-31.4
Maine	126,703	85,578	-32.5
Nebraska	141,070	94,836	-32.8
Indiana	460,244	308,654	-32.9
Arkansas	243,162	162,811	-33.0
Iowa	228,645	150,816	-34.0
Wisconsin	412,352	268,124	-35.0
Minnesota	370,668	240,919	-35.0
California	1,915,888	1,222,669	-36.2
Ohio	875,165	558,505	-36.2
Vermont	47,494	30,174	-36.5
West Virginia	161,348	102,076	-36.7
Michigan	683,236	427,889	-37.4
Pennsylvania	958,656	585,871	-38.9

State	2010	2024	% Change
Illinois	735,742	442,164	-39.9
Rhode Island	71,237	41,940	-41.1
New York	928,961	539,940	-41.9
Massachusetts	389,411	223,418	-42.6
Connecticut	220,631	126,248	-42.8
New Jersey	445,354	246,359	-44.7
Total	21,370,075	15,420,027	-27.8%

Source: United States. Census Bureau. "2010: ACS 1-Year Estimates Detailed Tables. Age By Veteran Status By Poverty Status In The Past 12 Months By Disability Status For The Civilian Population 18 Years And Over." nd. Data.Census.Gov; United States. Census Bureau. "2024: ACS 1-Year Estimates Detailed Tables. Age By Veteran Status By Poverty Status In the Past 12 Months By Disability Status For The Civilian Population 18 Years And Over." nd. Data.Census.Gov.

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