

THE SILVER TSUNAMI: IS VA READY?

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OF THE
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TUESDAY, MARCH 3, 2020

U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:32 a.m., in room 210, House Visitors Center, Hon. Julia Brownley [chairwoman of the subcommittee] presiding.

Present: Representatives Brownley, Lamb, Brindisi, Cisneros, Sablan, Dunn, and Meuser.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning, everyone, and welcome to the Subcommittee on Health, today's hearing on "The Silver Tsunami: Is VA ready?"

America's health care systems are bracing for the coming demands on its systems as one of the largest generations in American history enters their later years. Compounding this demand is an issue the subcommittee knows well, a harrowing shortage of providers. The Institute of Medicine predicts that by 2030 the United States will need an additional 3.5 million doctors, nurses, and other professionals to care for seniors. Of the roughly 19 million veterans alive in the United States today, 9 million are 65 years or older. While the total number of senior veterans is projected to decline into the foreseeable future, this population is the largest age cohort and will remain so for decades.

About 3.2 million veterans over 65 are enrolled in Veterans Health Administration (VHA) and one half of those have service-connected disabilities that entitle them to VA's institutional care services. In recent years, stakeholders have largely focused on VA's community care and caregiver programs. While these are essential areas for VA to get right, the scale of the Silver Tsunami is something VA cannot afford to get wrong.

Millions of veterans and their families are relying on us to ensure their later years are as dignified and healthy as possible. I am concerned that in the year since our field hearing in my district on long-term care nothing about VA's overall strategy or communication of any strategy has been made clear. To make matters more confusing, at last week's budget hearing Dr. Stone told the committee that VHA is preparing an elder care strategic plan that will be released soon, yet there is no mention of it in VA's testimony today.

Over the next 17 years, VA will have doubled its spending on long-term care services, nearly \$15 billion, as the largest cohort of veterans, those of the Vietnam era, come into their older years. These veterans, mostly baby boomers, will live longer in old age than any generation before, but with more complicated health needs and disabilities than any American health system has ever had to contend with.

In 2019, a half a million veterans used VA's long-term care services; of these veterans, 28 percent were 85 years or older. Most have a disability, a chronic disease, or are low income, and around one third live in rural areas. Eighty percent of VA's community living centers had vacancies for nurse assistants and home health aides. In 4 years, one million veterans with service-connected conditions will be eligible for nursing home care from VA, but this upswing in demand has already begun. Nearly half of VHA users are over the age of 65 and in just the previous 4 years VA's long-term care spending has increased 33 percent from \$7 billion to \$9 billion.

Long-term services and support is what VHA spends the most money on; that spending will only continue in the following decades. How VA plans to meet the complicated needs of veterans in these difficult and expensive years is what we hope to learn today.

Additionally, as we discussed last month, the veteran population is changing and this cohort of aging veterans is more diverse than ever before. We are eager to learn how VA's geriatric and extended-care program is working to ensure its programs, institutional and non, are designed to meet the needs of more women, more LGBT folks, more Native veterans, and more veterans with complex mental health needs.

Last month's Government Accountability Office (GAO) report on VA long-term care highlighted three key challenges: a workforce shortage, geographic mismatch of where services are and where veterans are, and a struggle to meet the need for specialty care, particularly behavioral health, in the geriatric population. VA must address these challenges. The scope of the Silver Tsunami is unlike anything the United States has ever seen before. VA has been and I hope will continue to be the leader for the rest of America's health care systems to model after, from innovative home-based programs to community partnerships, to holistic institutional care, VA has the tools to meet the needs of this large, diverse patient population, how they plan to get there is what we wish to discuss today.

With that, I would like to recognize Dr. Dunn for 5 minutes for any opening remarks he may wish to make.

OPENING STATEMENT OF NEAL P. DUNN, RANKING MEMBER

Mr. DUNN. Thank you very much, Chairwoman Brownley. I appreciate being here with you this morning to discuss the provision of long-term care to the increasing number of veterans who are elderly and members of the so-called Silver Tsunami. I do not know who came up with that, but it is kind of close to the bone.

There is no question that the veteran population is getting increasingly older. In fact, according to the Veterans Affairs Department, almost half of all the veterans enrolled are 65 years old or older. Many of the veterans devoted the prime of their life to our

country, defending our freedom, and it is our privilege and our duty to repay that service by ensuring that those same men and women are well taken care of now.

I am pleased to see that the VA has a number of services and supports to offer these veterans, including an increasing number of programs that allow them the opportunity to age in place in home rather than in nursing homes or other institutional settings. Our veterans earn their VA health care benefits and, whenever possible, we should honor their choices in how best to use those benefits.

I do share concerns detailed in the Government Accountability Office's recent report about the challenges facing the VA in meeting the significantly growing veteran demand for long-term care in a health care market that is increasingly tight. In addition to concerns about workforce shortages and difficulty meeting specialty-care needs, GAO also found a geographic misalignment between demand for those services and capacity for long-term care within the VA health care system. Such serious misalignment between where the veterans are and where the VA medical facilities is not limited to long-term care only, but I think we have addressed that with the AIR Act, the Asset and Infrastructure Review Act, which was included as a component of the MISSION Act in the last Congress.

AIR creates a blueprint for the VA health care system can be re-aligned and brought up to date to meet not only the needs of today's veterans, but also the provision of long-term care as we proceed into the 21st century. Today's hearing is another sobering reminder of the importance of the AIR Act and I appreciate GAO for once again noting the serious repercussions that our Nation's will face if it fails.

In addition to AIR, MISSION also included a provision that would expand the Family Caregiver Program to the pre-9/11 veterans. That expansion has been long awaited and I understand that a proposed rule may be published in the Federal Register as early as this week. I look forward to that.

The expansion of the Family Caregiver Program will be life-changing to the elderly veterans who are eligible for it and their caregivers, who for far too long have been laboring on behalf of their loved ones without the help and support of the VA and the Family Caregiver Program.

As we discuss in detail during today's hearing the needs of our Nation's veterans, many of whom have co-morbid conditions as a result of their time in uniform, their care only gets more complicated near the end of their life. An expanded Family Caregiver Program will have to be ready to meet those needs, as well as the needs of the caregivers themselves who are themselves aging. I expect we will have a hearing in the coming months on the Department's proposal for expansion, but given the serious impact that it will have on the growing numbers of elderly veterans, I look forward to beginning that discussion this morning with you as well.

I am grateful to all of my colleagues for being here and to the witnesses for being here. With that, Chairwoman, I yield back. Thank you.

Ms. BROWNLEY. Thank you, Dr. Dunn.

We have two panels today. With us is Dr. Teresa Boyd, the Assistant Deputy Under Secretary for Health for Clinical Operations at the Department of Veterans Affairs. She is accompanied by Dr. Beth Taylor, Chief Nursing Officer at VHA. Dr. Scott Hartronft—close, but—the Executive Director of the Office of Geriatrics and Extended Care at VHA. Dr. Elyse Kaplan, the Deputy Director of the Caregiver Support Program at VHA.

Joining us from GAO we have Ms. Nikki Clowers, the Management Director of GAO's Health Care team, and she is accompanied by Ms. Karin Wallestad, Assistant Director of the Health Care team.

With that, I now recognize Dr. Boyd for 5 minutes. Welcome.

STATEMENT OF TERESA BOYD

Dr. BOYD. Thank you and I appreciate the opportunity.

Good morning, Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the subcommittee. I appreciate the opportunity to discuss VA long-term care and veterans' choices for care as they age or face catastrophic injuries or illnesses.

I am accompanied today by Dr. Beth Taylor, Chief Nursing Officer; Dr. Scotte Hartronft, Executive Director, Office of Geriatrics and Extended Care; and Dr. Elyse Kaplan, Deputy Director, Caregiver Support Program. We proudly represent the professional team approach provided within VA's interdisciplinary and integrative health care system.

VA is committed to optimizing the health and well-being of veterans with multiple chronic conditions: life-limiting illness, frailty or disability associated with chronic disease, aging, or injury. Geriatrics and Extended Care (GEC's) programs maximize each veteran's functional independence and lessen the burden of the disability on veterans, their families, and their caregivers.

As veterans age, approximately 80 percent will develop the need for long-term services and supports. Most of this support in the past has been provided by family members, with women providing most of that care. The average number of potential family caregivers per older adult in America is currently seven, but that will likely decline by 2030. The availability of these potential family caregivers can be jeopardized due to work responsibilities outside the home. Moreover, many veterans are divorced, have no children, are estranged from their families, or live long distances from family members.

The aging of the veteran population has been more rapid and represents a greater proportion of the VA patient population than observed in other health care systems. Addressing the needs of aging veterans was recognized as a priority in 1975, which led to the development of 20 currently existing centers of excellence called Geriatric Research, Education, and Clinical Centers, or GRECCs, within VA. These GRECCs have served as an incubator for research into health and health systems relevant to older veterans and spawned innovative clinical programs that have been shown to optimize veterans' function, prevent unnecessary and costly nursing home admissions and hospitalizations, reduce unwanted and unnecessary tests and treatments, and thereby reduce health care costs where they have been made available.

While VA remains proud of our achievements in caring for our aging veterans, we acknowledge GAO's report highlighting areas where improvement is needed. We believe our existing GEC programs leave room for meeting the report's recommendations and our veterans' preferences. We will be meeting with Dr. Richard Stone, VHA's Executive in Charge, at the end of this month and presenting a way forward in developing those measurable goals. Moreover, the Choose Home Program, which began in 2018 with 21 pilot sites, will figure heavily into our strategic plan. We sincerely believe we have an opening to turn this Silver Tsunami into a golden opportunity.

VA provides a comprehensive spectrum of GEC services that surpasses all other U.S. health care systems. VA integrates care provided in the home, the clinic, the hospital, the nursing home, and incorporates care at the end of life spanning all settings.

In addition to integration of care, VA's spectrum of services effectively combines both Medicare and Medicaid, but includes social support and personal care services based on need rather than on income through services such as Veteran-Directed Care. Additionally, VA provides services such as home-based primary care, caregiver support, and Medical Foster Home, in addition to the Veteran-Directed Care that are not routinely available in other health care systems.

VA's various long-term care programs provide a continuum of services for older veterans designed to meet needs as they change over time. Together they have significantly improved the care, well-being, and dignity of our veterans.

Like many of my colleagues here from VA, this is personal and it is a humble mission. My father was a World War II veteran, aviation mechanic, and country physician, who was supported with community nursing home care and respite care in his final months of life. My eldest brother, who was a Vietnam veteran and a West Point graduate, who died at home with dignity thanks to VA Hospice.

Moreover, the care for our growing population of women veterans and our Native Americans can be considered in this vein and their independent needs are also continuing to be met such as the 101-year-old female veteran, an original Women Army Corps veteran who resides in one of our medical foster homes.

The gains VA has made in providing long-term care to veterans would not have been possible without consistent congressional commitment. Your continued support is essential to providing high-quality care for our veterans and their families, present and future. We also thank our partners at GAO for the excellent work they continue to do to assist in ensuring our veterans are being met with the best care possible, as well as a partnership with National Association of State Veterans Homes and Disabled American Veterans, who are sitting on the second panel today.

The previously mentioned 101-year-old female veteran has said, "I just can not believe that my service in the military all those years ago got me here in this nice place with all these nice people." VA's goal is to provide a level of service and care commiserate to the sacrifices veterans have made for our country. The bar is high, but we do intend to meet the mark.

Chairwoman Brownley, this concludes my testimony. My colleagues and I look forward to discussing this important topic further. Thank you.

[THE PREPARED STATEMENT OF TERESA BOYD APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Boyd.

I now recognize Nikki Clowers for 5 minutes.

STATEMENT OF NIKKI CLOWERS

Ms. CLOWERS. Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee, thank you for having me here today to discuss VA's efforts to address veterans' long-term care needs. I am pleased to be joined by my colleague Karin Wallestad, the lead investigator for our February report on this topic; my comments today will be based on that report.

Long-term care can address a range of needs, from occasional help around the house to ongoing clinical care. In 2018, VA provided or paid for long-term care for over 500,000 veterans, an increase of 14 percent since 2014. VA's spending on long-term care increased by 33 percent during this timeframe from almost \$7 billion in 2014 to over \$9 billion in 2018. VA's model projects growing demand for long-term care in the future. For example, VA projects that utilization of its Homemaker/Home Health Aide Program will increase by 84 percent from 2017 to 2037. With increased demand for long-term care, VA also projects that spending on these programs will more than double during this timeframe, topping \$14 billion by 2037.

According to VA's projections, the expected growth in these programs will not be uniform, with demand for care continuing to shift from institutional settings, such as nursing homes, to more non-institutional settings, such as aging at home with home health aides. As a result, spending on non-institutional programs is expected to increase by 170 percent through 2037, while spending on institutional programs will increase by about 70 percent during this timeframe.

Like other health care providers, VA faces challenges in meeting this demand. Our report highlighted three challenges. First, VA faces workforce shortages in certain positions such as nursing assistants. According to VA, these shortages have contributed to wait lists for appointments for some long-term care programs. Second, VA faces challenges making sure services are available where veterans live, especially in rural areas. Third, VA faces challenges finding appropriate long-term care for veterans with specialty care needs such as veterans on ventilators.

We made recommendations to VA to help them address these challenges. In particular, while VA has taken some steps to address the identified challenges, such as increasing the use of telehealth, VA lacks measurable goals to assess progress. We recommended that VA develop targets for these efforts. We also recommended that VA develop a consistent approach for managing all of its 14 long-term care programs and implement a standardized tool for assessing non-institutional program needs of veterans. Taking these steps would help ensure equitable treatment of veterans

regardless of location. VA agreed to implement these recommendations.

Chairwoman Brownley, Ranking Member Dunn, and members of the committee, this concludes my prepared remarks. Karin and I would be happy to take any questions at the appropriate time. Thank you.

[THE PREPARED STATEMENT OF NIKKI CLOWERS APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Clowers.

I will now recognize myself for 5 minutes for questions. This first is for you, Dr. Boyd.

The data proves out that the VA is not moving as fast as states are in terms of shifting its investments from institutional programs to non-institutional programs, and this tends to be a trend across the country and it is, from my perspective, which I have said over and over and over again in many, many hearings, non-institutional care, in-home care, whatever it might be, is more cost-effective and it is win-win, because that is what our veterans and their families want and desire. Institutional care is the largest program that the VA actually requires in terms of budgeting and making provisions in providing that kind of support to our veterans.

I am just wondering if there has been some thought, I do not see it in the current budget proposal, but some thought in terms of repositioning, you know, where we should be spending our resources. It seems to me that we should be shifting more of those resources out of institutional care and shifting those moneys into non-institutional care, which we will get a better bang for our buck and we will make veterans and their families happier. Can you speak to that at all?

Dr. BOYD. Sure. Thank you. You are absolutely right and, once we have our strategic plan presented and vetted with Dr. Stone, we would be more than happy to come back and discuss with the staff as well, but in the interim what we have learned from our Choose Home pilot validate exactly what you just spoke of. Veterans want to spend as much time, as much of their life at home and that will require a shifting the focus from institutional care into plussing up and helping VA facilities in the field geographically to partner either with adult day health care centers or with the medical foster homes, with the Veteran-Directed Care. These are types of programs that will see absolutely plussing up because, you are right, they will save us money on the one side, but it is the right thing to do for veterans' preference, as well as their whole health.

Ms. BROWNLEY. Thanks. You know, I am really talking about a statutorily shift in requirement, because of all of the other non-institutional care programs there are only a few that are statutorily required. It is my understanding that if you look at VA medical centers across the country you will find, if they have any leftover funds, those funds may go to some of those other programs.

You know, in the data that you have provided I have really no sense of, you know, what that looks like across the country, where we have areas of excellence, where we have great, great need, because that is not being provided. As we continue this discussion, these are some of the things that I am going to be inquiring about.

Were you involved at all in Dr. Stone's Elder Care Strategic Plan that he mentioned at the budget hearing?

Dr. BOYD. I am involved in that presentation. It is interdisciplinary, including strategic planning, our Office of Policy and Planning, of course GEC—

Ms. BROWNLEY. You were involved?

Dr. BOYD. We are involved in that and it is a dynamic work in progress. We have not presented the actual final recommendations—

Ms. BROWNLEY. When do you plan on presenting it?

Dr. BOYD. Later this month. In keeping with the GAO's recommendation, that is our time line—

Ms. BROWNLEY. The timing of this hearing was poor.

Dr. BOYD. I know.

Ms. BROWNLEY. Okay. To the GAO, Ms. Clowers. I think you made some very good recommendations. It sounds like the VA is going to respond to those recommendations in terms of time lines and so forth that I think are absolutely critically important.

The shortage of personnel, you know, is a big issue, it is an ongoing issue, and something that we need to work really hard at. The thing that popped most for me in your report was this geographic—shift geographically of where support and facilities are. In your investigation in that, did you find any data that the VA has in terms of, you know, where these shifts are occurring, what the needs are where populations have shifted, where the voids and needs are and, you know, what—it sounds like there are facilities perhaps out there that are being under-utilized, and if that data was available?

Ms. CLOWERS. Yes, ma'am. When we were looking at this issue—and in fact we see this issue across programs at VA, not just in the long-term care, but we see where veterans have moved out of the Northeast to the South, so you do have in some places over-utilization or over-demand, and then you have the opposite in other areas as well.

Ms. BROWNLEY. Have you got specific data on that?

Ms. CLOWERS. I will turn to Karin.

Ms. WALLESTAD. We do not have much more specific data than that than sort of general trends.

Ms. BROWNLEY. Just that there is a shift?

Ms. WALLESTAD. Right. They are doing their market assessment, which they have told us will give them more detail, which then we could request in the future to have more specifics.

Ms. BROWNLEY. I am sorry, I did not hear the last—

Ms. WALLESTAD. They are doing their market assessment, which would provide them with more specific data, which we could also help to review and answer these questions.

Ms. BROWNLEY. You will receive that at some point in time after this hearing?

Ms. CLOWERS. The market assessments, we are working with VA, so we can start looking at those initial results this summer.

Ms. BROWNLEY. Okay, very good.

Ms. CLOWERS. Chairwoman, if I could just go back real quick to your question about the states. We have noticed the same observation across sectors with states being more aggressive in moving to

non-institutional care. Medicaid being the largest provider of long-term care services, when you look at that program, that shift from spending on non-institutional care versus institutional care crossed over in 2013, meaning they started spending more on non-institutional care during that period.

Ms. BROWNLEY. 2013.

Ms. CLOWERS. Yes, ma'am.

Ms. BROWNLEY. Thank you. I certainly have gone over my time, but I will now recognize Dr. Dunn for a little over 5 minutes.

Mr. DUNN. Thank you very—you are so kind.

Dr. Boyd—I am going to ask if everybody can kind of keep their answers tight, because I have a number of questions—Dr. Boyd, I understand the VA's proposed regulations pertaining to the expanded Family Care Program will be posted sometime this week, can you give us a sneak peek at what those might look like?

Dr. BOYD. I wish I could. I can defer to—

Mr. DUNN. If you can not, that is all right, I can wait the week.

Dr. BOYD. Okay.

Mr. DUNN. I just thought we might have some—

Dr. BOYD. We can have a drumbeat, Okay.

Mr. DUNN.—big news breaking here.

Dr. BOYD. A drum roll.

Mr. DUNN. Let me move on then. On our second panel, the—

Ms. BROWNLEY. Nice try, though. Nice try.

Mr. DUNN. Well, I mean, you know, I always want to get the scoop.

On our second panel, the Disabled Veterans, DAV, are going to testify their concern that the VA's Fiscal Year 2021 budget request for the Family Caregiver Program, in quotes, "assumes a reduction in the number of existing program participants," end quote. Does it really do that and, if so, where or why?

Dr. BOYD. I can defer to Dr. Kaplan for that.

Mr. DUNN. Okay, Okay. Good. Dr. Kaplan—

Dr. KAPLAN. Sure.

Mr. DUNN.—go right ahead and answer.

Dr. KAPLAN. Good morning and thank you for that question. I just want to let you know that I will be back next week to talk about the regulations in depth and the proposed rule. We have that scheduled, I believe, for next Tuesday. In terms of the budget for—

Mr. DUNN. Are you assuming a reduction in—

Dr. KAPLAN. No, we are not.

Mr. DUNN. Okay, that is a good answer. I did not think so either.

Ms. Clowers, can you elaborate on GAO's finding regarding the need for the VA to better co-locate its long-term care services with the veteran population that needs them?

Ms. CLOWERS. Yes. This goes to the challenge that we see where some facilities and programs are not located where veterans are now residing. I think the Chairwoman mentioned about a third of all veterans live in rural areas and so those are often veterans that do not have access to these programs, as well as veterans moved out of the Northeast to the South, we see gaps as well. Looking for opportunities to reach those veterans through different programs such as telehealth or maybe also—

Mr. DUNN. We in rural Florida thank you for that—

Ms. CLOWERS. Yes.

Mr. DUNN.—that attention.

Let me also—and I am not sure if this is for you or for Dr. Boyd—are you comfortable that the market assessments are being carried out pursuant to the AIR Act, which is part of the MISSION Act, considering the location demand capacity as we are doing these assessments?

Ms. CLOWERS. I think that would be best for VA. We do have a request that we look at the market assessments for this committee and we will be starting that later this summer.

Mr. DUNN. Okay, so you are going to be looking at the marketing side of that.

Dr. Boyd, your testimony noted there is an urgent need to accelerate the availability of home-based care, what actions are you taking in order to meet that need?

Dr. BOYD. A couple things just before we get to the strategic plan that we will be glad to brief you on. We do know that with home-based primary care is far better services with regards to fiscal cost and it is what the veterans want. What we are doing is looking at the standardized approach to the staffing of that, as well as the delivery of that, and in addition to encompass the other programs that wrap around.

Remember, elder veterans, our elderly population do not just get one service, you know, so we are plussing up as well.

Mr. DUNN. That is good. What can we do to help you here on this committee?

Dr. BOYD. Your continued commitment—

Mr. DUNN. What can this—legislatively—

Dr. BOYD. Well, your continued commitment to having these hearings is very important, believe it or not, this is good for us, and we look forward to coming back and talking to you about this.

Mr. DUNN. Again, I think, to Dr. Boyd now. When a veteran is in need of nursing home care, what steps are taken to honor that veteran's preferred setting and location, whether it is at home or in a center and where the center is, what steps?

Dr. BOYD. I can briefly give that to Dr. Hartronft, who lives this.

Mr. DUNN. Yes.

Dr. HARTRONFT. Yes, sir. Usually, it is the discussion with a primary care provider is the starting point with many of these cases, who then works with a group, the social worker and other clusters on the Patient Aligned Care (PAC) Team, and then they really—then they put in a consult for our non-institutional care programs. Again—

Mr. DUNN. You are comfortable a real effort is made to meet their requirements. I will say that in our constituent services back home we get dragged into the—you know, on the back end of these when the veteran is someplace he does not want to be or she does not want to be. I see that on the far end of that, so I do not get to see it work well on the front end; I hope it does mostly.

This is my important question I want to get to—thank you for my extra 30 seconds here—the coronavirus, COVID-19 is coming at us. The nursing homes, the VA nursing homes are a set-up risk for that kind of thing and we are talking about people with mul-

tiple co-morbid conditions, what are we doing to prepare for that and what advice would you give a veteran who is in a VA nursing home system right now?

Dr. BOYD. I can start off on that very quickly. This is near and dear to us every single day. While COVID-19 is a new virus for us, we have tremendous experience with highly infectious diseases—

Mr. DUNN. Flu, right.

Dr. BOYD.—within those, whether it be influenza, norovirus, so much of that is the same. If nothing else, please wash your hands, do not touch your eyes, do not cough, you know, outwardly, cough into the crook of your arm, and get the flu vaccine. While that will not help with the COVID-19, we do know that influenza is highly contagious as well.

Mr. DUNN. I think the same precautions help with COVID-19. We expect a thoroughly professional response, as usual, from the VA on that.

With that, Madam Chair, I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn. I will just add in terms of this geographic shift, there is also a tremendous void in Indian territory, in our territories, United States territories. With that, I recognize Mr. Sablan for 5 minutes.

Mr. SABLAN. Thank you.

Ms. BROWNLEY. You are welcome.

Mr. SABLAN. Thank you. Good morning, everyone. Dr. Boyd, if I may—

Ms. BROWNLEY. Microphone, Mr. Sablan.

Mr. SABLAN. All right, start over.

Dr. Boyd, let me—by law, the Veterans Millennium Health Care and Benefits Act required the VA to provide institutional care to certain service-connected veterans and also requires the VA to offer certain non-institutional long-term care packages as part of the VA medical benefits package. I come from a place where we take care of our own parents. We do not have—I will be honest, we do not have any aging homes or hospice homes. Maybe the population is not there or it is because we take care of our own parents. The Department currently sends veterans from my district to Guam, Honolulu, or the contiguous states for services that are unavailable in the Marianas. There are no VA local or community residential long-term care facilities and in-home care services are limited.

What is the VA doing now or what can the VA do now for my veterans needing long-term care? How is the VA supporting the veteran and his or her family? Connected with that is, while I am also lacking long-term care facilities and services, will the VA be moving Marianas veterans who need such care to Honolulu or the mainland, any idea?

Dr. BOYD. You bring up a really good point. Just so you know, this was actually discussed in many of our meetings that we have had over the prior months, so it is almost like you have been channeling this for us. I do not have all the answers yet, we do not have all the answers, but this is definitely on our forefront and what we are discussing, because whether it be in your area, the North Mariana Island areas, or some pockets even within the states where it

is—I know it is different, but maybe far away, we are struggling with those and we do need to continue those conversations.

I look forward to discussing that more with you, sir, with your staff—

Mr. SABLAN. That is probably why they call this the Silver Tsunami, because—I am not going to complain again. I was really frustrated in the last hearing with the lack of services my veterans get.

I have a question and maybe—I have a veteran who is retired also and he is diabetic, so they—Pacific Islanders, almost over half are diabetic—so they cutoff both his legs, I think right at his knees. He is kind of big, a little—almost as large as I am, I think—no, actually, as large as I am. His son quit working so he could help his dad, you know, get up from bed in the morning, get washed up, dressed, you know, come outside, meals, everything. Is there a program where that son could be compensated for providing that service or is there like a visiting home, nursing home? See, those nurses just come and check on the patient and the need for this veteran is 24/7.

Dr. BOYD. Very good question and Dr. Kaplan could have that—I mean, we could all answer that, but since she is here, I am going to take advantage—

Mr. SABLAN. Okay, thank you.

Dr. BOYD.—of her presence.

Dr. KAPLAN. Thank you for that question. While I can not speak to someone's eligibility for the program of comprehensive assistance, the MISSION Act has really afforded us the opportunity to expand our comprehensive program to veterans of any eras. Right now we are limited to veterans that have been injured in the line of duty after September 11th, 2001 and with the first phase of MISSION Act we will be expanding that to pre—so for May 7th, 1975 and prior, and then 2 years later injuries between May 7th, 1975 and September 11th, 2001.

There is an opportunity for support and services within the caregiver program, whether it is the comprehensive program or our enhanced general caregiver support and services.

Mr. SABLAN. Yes, thank you.

My time is up, Madam Chair, but thank you, thank you very much.

Ms. BROWNLEY. Thank you, Mr. Sablan.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Madam Chair.

I just want to say first, there has been a lot of attention so far at, I guess, non-institutional care or care at home, which I think is really important and I want to come back to, but I did want to plug quickly the VA hospital in my district, which is in Aspinwall, Pennsylvania, just outside the city of Pittsburgh. I visited their long-term care section I think twice and it is just such a credit to the VA as an institution. You know, they have these men in particular mostly who have been living there for quite a while and the nurses will bring food from home or food from the outside and cook like a home-cooked meal for them in this kitchen that they have set up. These people really go out of their way to make it feel like an actual home and not an institution and, to me, that is the model.

There is always going to be some people who are going to need that institutional care and the more—I think VA is so uniquely positioned to make it just a lot sort of better and more informal and comfortable than it might be anywhere else. I just wanted to compliment that nursing staff in particular in Western Pennsylvania.

I think it does help remind us, the way you get there, it is partially about culture, but it is partially about, I think, the way those nurses have been treated throughout their career. You know, they have been paid well, they are members of a union, they are looked after, they have job security; they obviously feel very passionately about the veterans they are serving, you know, they care about the cause. I remember a lot of them telling me their fathers were veterans and that sort of thing. That is just part of the VA institution that we cannot afford to lose and I think as we go forward we want to stay mindful of that, that when you treat people right, they treat the veterans right.

With all that in mind, I did want to ask, there is clearly going to be a need to hire not only nurses, but also home health aides, because we are going to move less in the institutional direction probably in the future. That also happens to be the most growing and in-demand job in America as a whole, so everybody is trying to hire these people. I was wondering if you could just kind of clue me in. I know you have a plan coming out, but what is the plan for the VA to get the best of the best, so that the next generation of veterans is treated as well as the ones I have seen? Go ahead.

Dr. BOYD. Congressman Lamb, first of all, thank you for that information about the Western Pennsylvania Community Living Center (CLC), I will definitely pass that on.

I have with us today, of course, Dr. Taylor, and we are in constant conversation about this, so I would like her to help you with that.

Ms. TAYLOR. Thank you very much, and thank you for your comments about the nursing staff in Western Pennsylvania. As a nurse with many veterans in my family, it is an honor for us to serve those who have served, and I know many of my colleagues, most of my colleagues across the country feel very passionately about our mission. Thank you, sir, for recognizing that.

We are putting a lot of energy and effort into ensuring that we have our hiring initiatives and our positions filled. For long-term care in particular, from Fiscal Year 2018 to Fiscal Year 2019, we actually increased our on-board strength in nursing assistants by 5 percent. Not a lot, but certainly a good uptick from year to year, year over year. In that same time period year over year, we increased our RN on-board strength by 6 percent for long-term care programs. We recognize that it is really important to make an investment and to be very assertive in our recruitment efforts.

The other thing that I just want to mention is we have in VHA a fairly healthy scholarship program that is attractive to nurses coming in the door, because they see us as not only a great mission where they can get fair compensation—of course, we can not be market leaders, but we can compensate fairly with good benefits—

Mr. LAMB. That is great. I am sorry to interrupt, but we do have limited time. What about the home health aide category? Not really

nurse, but the type of people who in the civilian world right now are sort of lucky to be making 13 or 15 bucks an hour.

Ms. TAYLOR. Yes. Those fall into the same category as nursing assistants and so we have seen an uptick in our hiring for those. Thank you.

Mr. LAMB. Okay, thank you.

I just want to leave you with this thought to take back. I know this decision is not totally in your hands, but the VA is not being kind to Federal Employees union in a lot of places around the country. There is some variability based on local leadership, but under this Administration they have locked them out of offices, they have made it difficult for the union officials to do their jobs, and the type of the people who are going to take a home health aide or nursing assistant job are often the people who need that sort of protection and support the most. I think for us to recruit the best of the best in that category for the next generation you are going to want the people who are already there telling their friends, hey, VA is a great place to work; they stick up for us, they pay us well, they take care of our needs. If we get sick and we have to miss, we are covered, you know, that sort of thing. We are going to lose that if it becomes a hostile environment, particularly for people on the lower end of the scale.

Please take that back and just try to reinforce that important part of the culture. Thank you.

Madam Chair, I yield back.

Ms. BROWNLEY. Thank you, Mr. Lamb, and thank you for raising that important issue.

Before I excuse the panel, I have a few more questions. If anybody else here has a few more questions, I will recognize you.

I wanted to get back, you know, again to this moving from institutional to non-institutional, but even within the statutorily institutional care, Dr. Boyd, is there are—I know that the Association for State Veterans Homes will be on the second panel—there is the medical foster care program. The point I want to make is that state homes are less expensive than beds provided by the VA, which gets back to the economics of all of this, and maybe better care. I know I have a state home in my district and it is extraordinary. I do not know if every state home across the country is extraordinary, but the one in my district is truly extraordinary. We know state homes are cheaper, yet we are not providing the resources for them to expand, to renovate, so forth and so on. Again, medical foster care is less expensive.

You know, just in terms of sort of that long-term care that is needed, why is the VA not again shifting, you know, just within that kind of category, shifting more toward some of the other—not shifting, but adding to, because it is clear there is not enough beds and there is not going to be enough beds, so to the degree that we can expand upon that through state homes and other programs. I am talking about people who are going to be in a place for a long period of time and are going to be eating and sleeping there, et cetera, that is kind of what I am talking about. Is the VA thinking about that or, you know, trying to evaluate this again for better service for the veteran and a more economical decision where those

additional resources, savings, can be invested back into, you know, other programs for our aging population?

Dr. BOYD. Absolutely, and I can address especially the Medical Foster Home Program, Chairwoman Brownley.

Absolutely, and especially when we take GAO's observation, very insightful observations that indeed we have a mismatch where our brick-and-mortar from many, many, many years ago and as our veteran populations have moved, it makes the most sense that where veterans live they can go and seek out and find a medical foster home that feels right to them; it is less stimulation, it is more home-like. That is part of our strategic plan, just a little glimpse into that, is to push that most definitely.

Ms. BROWNLEY. What about the state nursing homes?

Dr. BOYD. The state veterans homes, again—and I can let Dr. Hartronft jump in on that, if you would like to—sometimes some of the special populations that we have within a VA nursing home would probably not be the most appropriate for the state veteran home. I am not saying that is an all across the board. Dr. Hartronft, if you wanted to just mention that, because you are absolutely right, it is a valuable partner for us.

Dr. HARTRONFT. Yes, we are very lucky to be able to work with our partners in the states to really identify which veteran populations. If you really look at it, the number of long-stay veterans who really live at the home for longer periods tend to be in the state veterans homes, versus our contract nursing home and our community living centers tend to be shorter stays, post-acute and other things like that.

They definitely have a type of demographic that we work well together with them in. I agree, we work closely with the states whenever they apply for having an additional home, we have processes to look at that and encourage that.

Ms. BROWNLEY. You agree that we need more assisted living services, you know, for the VA, because as the population grows, you know, the need for that kind of thing on an ongoing basis and not a temporary basis, it is going to be greater and greater. Do you agree?

Dr. HARTRONFT. Yes. I think especially the areas that we can work with, including not the nursing home part, but also the adult day health care and state veterans homes, and then also working with them and others as to really the domiciliary sections as to what are some of the best things we can maybe encourage and improve in those areas.

Those are areas we are looking at and working toward.

Ms. BROWNLEY. Okay. Then just very quickly, I just have a request. I am not asking for an answer today, but if—between the GAO and Dr. Boyd—if we can identify all of the non-statutory programs within the long-term care, if we can identify, you know, describe to me their uses, where there are voids in some of those services, and how much money on a Fiscal Year is being spent in all of those programs, so that I can get an idea of how these other non-statutory programs are being utilized.

If you could provide that information, that would be very helpful to me.

Dr. Dunn, do you have any additional questions?

Mr. DUNN. Thank you very much, Madam Chair, so I do too. I am going to follow on the same conversation that Chairwoman Brownley had there about the cost of some of these things.

I tried to parse out of the budget request what the, you know, numbers look like for in-patient and out-patient long-term care. I could not really get the out-patient number on a per day, per patient number, so this is something, I think, that the average citizen can make sense out of. I think we got a pretty good grip on what the long-term in-patient nursing home care costs were for patients, per patient per day or per patient per year. In 1919, the nursing homes, the VA nursing homes, all the different varieties, the average was \$1,183 a day, 365 days a year for those services. That is \$431,800 per year per patient in VA long-term care. That went up in 2021, the Fiscal Year we are looking at budgeting right now, it goes up to \$464,000 and change, a \$33,000 increase, and for 2022, it is posited to go up to \$493,000 per year per patient in the system. Now, if you think about it, you are spending over \$1,300 a day per patient.

Now, I have actually paid for family members in nursing homes and I feel quite comfortable that we got very good nursing homes and the numbers that we spent were nothing like that. Can you shed light on why it costs the VA so much to do that and what might that look like if it were done at home?

Dr. BOYD. I will take the first part of that. Thank you for that, Ranking Member. What we do know, and we broke this out for you. It must have been hearing that. The medical foster home care that we talked about earlier, and if we add the requirement that the veteran is followed by home base primary care, that comes out to \$53 a day.

Mr. DUNN. So—

Dr. BOYD. Verse, I mean, that is—

Mr. DUNN. Versus \$1,000, \$1,200, \$1,300 a day, \$53 a day.

Dr. BOYD. Absolutely.

Mr. DUNN. That is a pretty favorable comparison.

Dr. BOYD. That is why the push to try to—that is a great opportunity for us to have communities work with folks within those communities to set up those foster homes, the medical foster homes, and to partner.

Then if we were just to go to our home base primary care, that is \$44 a day on average, just that alone, versus our aggregate—and GAO gave us this information, it is about \$15 a day for the non-institutional care program, just alone, by itself. There is a huge spectrum—

Mr. DUNN. That comparison is very favorable. I want to thank you for that. I mean, wow, that is 20 times more expensive to go, or more.

Dr. BOYD. Yes.

Mr. DUNN. Anyway, what can we do to lower the number on the inpatient side, because surely that does not need to be that high?

Dr. BOYD. Dr. Hartronft, who has managed those inpatient units can actually, and from his expertise can give you a little bit of insight about the Community Living (CL) fees cost.

Dr. HARTRONFT. Yes. I think a lot of this is reflecting some of the populations that we continue to keep in the community living cen-

ters. As you know, the community living centers per bed day of care cost is more expensive than contracting nursing home in the community. I think right now what we are going to be doing is working with the Office of Nursing and others to really find out what is the best staffing models of care. We are going to be reviewing that as to, you know, how do we reflect differently from the community staffing and for what reasons, because part of it is having the right veteran of the right area. If they have to be in a facility, many times it may not be—

Mr. DUNN. We are going to have this discussion more this year—

Dr. HARTONFT. Yes, sir.

Mr. DUNN.—during this year. I just want to say, I mean, the difference here, I mean, you are talking—if I could find the nicest nursing home on Georgia Avenue in Northwest Washington does not cost half of that. I mean, this is not a marginal thing with the staffing thing. There is a huge disconnect here.

I know you do not have the answer today, but please know that we are interested in hearing that answer, because we have to be more efficient than that.

With that, Madam Chair, I yield back.

Ms. CLOWERS. Dr. Dunn, may I add something very quickly on this particular issue. Even when you are looking at the institutional side with the averages, that can mask very different cost per setting.

That is one of the things we provided in the report, and Karin could provide it per day, but you have at the very top level the community living centers in terms of cost, down to the state veterans home, which is significantly different.

Ms. WALLESTAD. Sure. For the CLCs, it was about \$1,074 a day; for the community nursing homes, \$268; and for the state veteran homes, \$166.

Mr. DUNN. For the VA community living centers, \$1,200 a day.

Ms. WALLESTAD. Approximately.

Mr. DUNN. That is—I mean, just the comparison along that line makes you think you want fewer VA community living centers. Right?

Ms. CLOWERS. Well, it has to do with both—with who is paying for those services. With the state veterans homes, you have the States contributing money as well. There is a number of factors that could go into the cost, and we are happy to have additional conversations with you and your staff about—

Mr. DUNN. Yes, yes. I see the proper, apples to apples numbers.

Ms. CLOWERS. Right.

Mr. DUNN. Thank you so much.

Ms. BROWNLEY. Thank you, Dr. Dunn. Mr. Sablan, you are recognized for an additional question.

Mr. SABLAN. Thank you, Madam Chair. My question earlier, I got the answer that VA can not help that individual whose son had to actually quit his job so he could take care of his dad, because there are no long term care facilities in my district, and since there are no permanent primary care provider, or non-institutional programs like the caregiver programs or the home base primary care are not allowed for those veterans to program regulations.

The problem is, I will take care of them—does not allow it. I am going to ask again. I am going to continue asking this until somebody hears what I am asking. In my district, and I am sure that there may be other parts in the country, very isolated, rural areas, in my district, there is I think one VA staff who does the admin appointments and those kind of things. No VA staff provides direct care services, or they are very limited now.

We have no Community Based Outpatient Clinic (CBOC), no vet center, no Veterans Benefits Administration (VBA) staff. I really—I am trying to find who to talk to, where to start, where we could start building—like building blocks, you know, a vet center, for example. Dr. Shuytkin (phonetic) and I started working on this and then he lost his job. I can not hold Dr. Secretary Wilkie to it, but really just provide some kind of service to the veterans living there. The numbers are going to grow because, you know, there are many who are joining the service. There are many who are signing up in Honolulu, or Washington State, and then we are helping them change their record of—home record, I think is what it is called, so that when they exit, they get to go to the Northern Marianas.

Thank you very much for your time. Yes, my answer to that kid who is helping his father out, because if he does not, no one else will, can not get anything because the regulations does not allow it, unless somebody at VA would like to change the regulation to allow it. Thank you.

Dr. BOYD. If I could just a moment, Congressman Sablan, off line, I would be most interested in learning the name and the specifics about this veteran, and we can put our heads together and see what, in fact, might be available. I would do that off line.

Mr. SABLAN. May I contact him and ask him?

Dr. BOYD. Absolutely. We would like to look at it for you.

Mr. SABLAN. Yes. That would be a huge load. He needs help.

Dr. BOYD. Okay.

Mr. SABLAN. He takes it out here, this one. In my ear, but thank you very much. It is a veteran. He served 20 years, so—

Dr. BOYD. Okay. Okay.

Mr. SABLAN. Thank you very much.

Dr. BOYD. Thank you.

Ms. BROWNLEY. Thank you, Mr. Sablan, and thank you to the panel for being here today. We are going to excuse you and call the second panel. Take a few minutes to reorganize ourselves.

[Recess.]

Ms. BROWNLEY. Welcome to our second panel. We have Mr. Adrian Atizado, the deputy national legislative director for Disabled American Veterans; and Mr. Mark Bowman, the president of the National Association of state Veterans Homes. Welcome. With that, I now recognize Mr. Atizado for 5 minutes.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Madam Chair, members of the subcommittee, first, I want to thank you for conducting this critical oversight hearing and calling attention to an essentially often overlooked program that VA should very much be proud of. It is there long-term services and supports program.

As has been mentioned by the previous panel, the VA has come a long way since two seminal laws were passed in the 1990's that really transformed how VA provides care to veterans. In that sense, also changed the way the operating environment that VA's long-term services and supports system operates.

Historically, aging veterans in a veteran population has had less of an impact on VA expenditures that might be expected, because reliance on VA by these veterans tend to drop off when they hit 65, because they become Medicare eligible.

More recently, however, this trend has seen a reversing—in other words, the amount of reliance is no longer declining, it is actually—the decline is actually not in a downward—as much of a downward trajectory. Reliance on certain VA Long Term Services and Supports (LTSS) does not decline after Medicare eligibility due to the limited Medicare coverage for institutional long stay nursing home services, as well as non-institutional services. Older veterans' preferences and needs remain—to remain in their home and community have evolved, and are generally no longer met by the Medicare program. Accordingly, VA's budget and expenditure projections assumes a slightly higher level of reliance from over 65 veterans.

Now, in light of increasing numbers of veterans needing LTSS or long-term services and supports, their evolving preferences and needs, and VA's current long-term service and supports system of care, DAV's main concern is whether service-connected veterans are getting the services and supports they need today, and if they can also do so in the future.

Members of the DAV passed resolution as our most recent convention. The resolution recognizes three things: a large and glaring gap in VA's long-term services and supports program, with statutory authority prohibiting the department from paying for care in the community residential care facilities, despite referring veterans to these facilities and inspecting over 1,300 of those facilities.

It also recognizes the ability for veterans to remain at home is critically dependent on veterans' caregivers, whether they are families or friends. A third is that the resolution asserts VA home and community-based services, and their programs are not uniformly available at all VA facilities, resulting in inconsistent availability, as well as wait lists.

This resolution allows us here today to call on Congress and the VA to improve and enhance the Department's LTSS system, and to ensure each VA medical facility is able to provide service connected civil veterans' timely access to both institutional and non-institutional services. DAV recognizes that most LTSS users have a high burden of service connected disability. They are catastrophically disabled or are of low income. About a third live in rural areas.

LTSS is not just for aging veterans. Nearly 17 percent of VA's LTSS was provided to veterans under 65. Meeting their needs will require VA leadership at all levels to make LTSS a higher priority than it is today.

In my written testimony, there are a number of bills seeking to improve and expand VA LTSS, as well as VA's caregiver support program, which is a critical long-term service and support component, not formally recognized my statute. We urge the subcommittee to consider them favorably.

Finally, we call on VA to expand its veteran directed care program, which gives the veteran control over how their needs are met at home. Under this program, VA is able to serve three veterans for every one residing in a community nursing home at VA's expense. As of this writing, the veteran directed care program is available only at 69 out of a 170 VA medical centers across 37 states, DC, and Puerto Rico.

Madam Chair, DAV is pleased to have had this opportunity to revisit the topic of VA LTSS and its system of care for veterans. We look forward to working with the subcommittee to ensure veterans continue to have access to a full array of long-term services and supports, no matter where they decide to reside. Thank you.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Atizado. I now recognize Mr. Bowman for 5 minutes.

STATEMENT OF MARK BOWMAN

Mr. BOWMAN. Chairwoman Brownley, Ranking Member Dr. Dunn, and members of the subcommittee, thank you for inviting the National Association of state Veterans Homes (NASVH) to testify on the future of long term care. The state Home program is a partnership between states and Federal Government, with the VA providing a per diem payment, covering about 30 percent of the cost of care, with the states using a variety of sources to make up the difference.

The VA also provides construction grants to cover 65 percent of the cost to build, renovate, and repair homes with states matching 35 percent. Today, there are 157 state homes in all 50 states and the Commonwealth of Puerto Rico, providing skilled care, domiciliary, and adult day health care.

State homes provide over half of all the VA funded institutional care, but account for less than one quarter of VA spending. According to VA, the institutional per diem for State homes is 40 percent lower than private community homes, and less than one-sixth of the VA's community living centers.

Investing in state homes is the most cost effective way of maximizing Federal dollars to provide care for veterans who have no home based options. Chairwoman Brownley, to strengthen and sustain homes, Congress must provide adequate funding. For Fiscal Year 2021, VA requested just \$90 million for state home construction grants, despite an estimated \$1.2 billion Federal share for pending grant requests.

NASVH asked Congress to appropriate \$250 million to fund half of the priority one list, which includes life and safety projects. State homes must pass annual inspection surveys by VA in order to remain certified. However, homes that receive support from Medicare must also undergo a virtually identical annual inspection by Centers for Medicare and Medicaid (CMS), wasting time and resources.

NASVH strongly supports HR-4138, bipartisan legislation to coordinate a single Federal inspection survey, conducted by VA and accepted by CMS. State homes are required to provide basic primary care, but specialty care remains VA's obligation. However, VA has been treating mental health care as a state responsibility.

Given the high cost of psychiatrists and psychologists, who are specialists, state homes may be forced to stop admitting veterans with significant mental health issues, leaving fewer options at a time when veteran suicide is a national crisis and a top VA and congressional priority.

Chairwoman Brownley, domiciliary care programs provide alternative long-term support for veterans who do not require skilled nursing care, but need help with food, shelter, and support of services. Currently, there are doms in 30 states, including California, Florida, and Pennsylvania.

Unfortunately, regulations adopted in 2018 increased the cost to operate domiciliary programs without any increase in reimbursement, forcing a number of states to consider closing their doms, potentially putting thousands of veterans at risk of becoming homeless.

We ask you to work with us and VA to address the eligibility and staffing problems caused by the new regulations.

Looking to the future, state veterans homes are ready to partner in new and innovative ways to meet the changing needs and preferences of veterans. For example, a number of state homes would be willing and capable of providing care for veterans with behavioral issues or mental illness if a higher per diem were available.

Many state homes have interest in providing enhanced domiciliary care to fill the gaps between skilled nursing and dom care, including for veterans with dementia. State homes providing adult day health care could also operate other home based programs to meet all the needs of veterans who want to remain in their homes. However, in order to fully utilize the capabilities of state veterans homes, the VA must commit itself to a true partnership. We are too often an afterthought in VA's planning and budgeting processes.

For example, GAO found that the VA's future budget projection models do not even include state veterans homes. We had no representation on the VA's geriatrics and gerontology advisory committee, despite NASVH nominating three highly qualified individuals. With a budget topping \$1.5 billion, it is time for VA and Congress to consider establishing an office for state veterans homes to oversee all aspects of our programs.

Finally, it is important to realize that in total, VA supports about 40,000 nursing home beds. This is less than one half of 1 percent of the estimate 9 million veterans over the age of 65. While there is certainly a growing need for non-institutional care, the need for traditional nursing home care is neither diminishing, nor will it ever go away.

This concludes my statement. I would be happy to respond to questions.

[THE PREPARED STATEMENT OF MARK BOWMAN APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Bowman, and I will now recognize myself for 5 minutes for questions.

Mr. Atizado, you know, I have sort of a broad question for you, just in terms of your members, and you are a good indicator, or your members are a good indicator of how we are doing and where

we need to go. You pointed out some of that, I think, in your testimony.

If you could talk a little bit about the experiences your members are having in terms of navigating care for Alzheimer, dementia, and other behavioral health issues. If you could talk a little bit about your membership in terms of State nursing homes. I do not know whether your members are in state nursing homes, or they predominantly use the CLCs.

Mr. ATIZADO. Thank you for that question, Congresswoman Brownley. Yes, a lot of service connected veterans reside in state veterans homes. They are very satisfied. It is a great setting for them to—to have long stay nursing home care.

I visited a handful of them myself, and I am always impressed with the commitment of the staff, and the environment of care. When it comes to a very special sub-population of the veteran population, like you said dementia, Alzheimer, behaviorally challenged, physically capable but behaviorally challenged veterans. I can tell you, every VA facility, nursing home facilities know these individuals by name. They can count them on their hand. They have a lot of—there are a lot of problems trying to find them supportive housing. The system is just not set up for them, because there is so few of them.

I know VA has been struggling to address this situation, especially for the behaviorally challenged. It requires a different set of staffing models. I believe state veterans homes are experiencing this as well, and we are hopeful that both the state veterans homes and the VA can partner to try and find a way to address this.

The only thing I want to caveat, though, is in the community, memory care facilities or patients with dementia who go to these memory care facilities generally are aligned with assisted living facilities. If a veteran in the community that is not close to a VA CLC or community nursing home requires some kind of memory care services, and the only thing that is available to them is an assisted living facility, VA can not pay for it, because they are not allowed to pay for assisted living.

Those veterans, although while there is an option available to them, the statutory law actually disallows VA from paying that kind of service, even though they need it.

Ms. BROWNLEY. Thank you. Just to follow up on that. In terms of all of the non-statutorial programs that the VA has in terms of long-term care, do you have a sense of—in terms of your membership, the demand on these programs and are they being addressed?

Mr. ATIZADO. On that side, Congresswoman, we actually surveyed back in 2007 about 1,100, almost 1,200 family caregivers and the veterans who have family caregivers. According to the survey, what they have told us is a very small percentage of them know they need it, but get it. I know VA has—and I want to make sure that VA gets credit in this. They have been trying to get their facilities across the country to have better visibility on veterans, such as the ones that we had surveyed, that are in need, but are not getting the services.

I think it was mentioned that there is—VA's policy is that every facility is supposed to have a tool to quickly assess veteran's in-home needs, whether it is respite care, home aid, or home health

aid. They leave it up to the facilities to choose which tool, even though there is one that is generally recognized in their policy.

The variability and the availability of that, because of that tool and how it is implemented, is what we see across the VA health care system. I understand there is a balance between dictating the field and what they should do versus allowing the field to create a system that is suitable for their patients. Because our survey shows that the majority of these veterans are not getting the services they need, we think there has to be a little bit—that policy has to be revisited.

Ms. BROWNLEY. Thank you. Mr. Bowman, do you have a breakdown of your clients in terms of sort of their needs within your nursing homes? I know there is obviously a lot of sort of generalized needs, but when it comes to dementia, Alzheimer, these behavioral issues, do you kind of have a breakdown of need within or that you are, indeed, providing within the state nursing home population?

Mr. BOWMAN. Certainly, each facility would have exact numbers for you, but I can assure you that a large part of the population that long-term care facilities serve, including state veterans homes, include dementia and memory-impaired veterans. That is just a large percentage of that population.

I think everybody would agree that that is going to continue to grow. I think that is the value of what this committee is doing, and everyone sitting at this table is to come together, not with existing structure in what we are doing, but work as true partners in looking to modernizing the health care delivery system for the future, not where we are out now, and that is why I value this discussion.

Those are—that is going to be a big component of that, and we have got to put our mind and our resources toward that end.

Ms. BROWNLEY. Thank you very much. My time is up, and so I yield to Dr. Dunn. That was much more than 5 minutes.

Mr. DUNN. Thank you very much, Madam Chair. No. That was a fascinating discussion and I agree. We need to get to the bottom of that. We need to talk more this year about how we can help each other in that area. We all recognize that growing need.

Mr. Bowman, in your testimony, you said that the state home model serves as a—they serve as laboratories of innovation that allows the VA and then other state models to take advantage of those programs. Can you give us a few examples?

Mr. BOWMAN. Yes, sir. For example, in a domiciliary program, even though that is a—we receive a fairly low per diem funding for many of the dom programs throughout the United States, the states have taken on that challenge and many times provide care above and beyond what is mentally required. That is including funding that through state resources. It augments the shared agreement with the Federal Government, but it is a true partnership, but they go above and beyond.

That is one of the issues that we also think is going to be a very valuable opportunity for all of us to look at is take that domiciliary program and like Adrian has talked about, a lot of the needs out there are outside the scope of that program. This is going to give us a perfect opportunity to say, “Look, when this program was instituted, it met a need. Is it meeting the needs for the veterans

that we serve today?" That answer is absolutely not. It has got room for mobility and innovation at the state, and the partnership with the Federal Government.

I think we can come up with some solutions in a more cost effective manner.

Mr. DUNN. I think I have seen some of that actually in my district. Tallahassee jumps out at me as a place that has done some of that work with co-locating and a lot of other services with the veterans domiciliary home. I applaud that effort.

To get at Chairwoman Brownley's numbers, we know we have a huge and growing need for memory wards. What is the—how much more expensive than domiciliary is that kind of—

Mr. BOWMAN. Well, when you look at a domiciliary level, that reimbursement does not even really touch the level of care that you need, say, in the nursing facility portion. Let us face facts. The only way to really address that problem is increased resources. It really comes in supervision and hands on care, because you can no longer apply the old models to that type of population that we serve.

Mr. DUNN. We have some technology that has streamlined that. I am intimately familiar with some of these problems. Do you have a figure for us? Okay. If we have a domiciliary care and we have a memory ward, what is the delta in cost?

Mr. BOWMAN. I can get those to you. I would be glad to submit some comparison numbers from our members. I would be absolutely glad to do that.

Mr. DUNN. I am sure it also affects the construction as well, right?

Mr. BOWMAN. Yes, sir.

Mr. DUNN. The construction—it is my understanding that the VA typically in these affairs, it is a match VA to state. The state puts up 35 percent, the VA puts up 65?

Mr. BOWMAN. Yes, sir. That is correct.

Mr. DUNN. That is standard across the country? There is no—

Mr. BOWMAN. Yes, sir. No, there is no deviation from that in the grant program.

Mr. DUNN. What kind of—and you said there were \$90 million in the next—

Mr. BOWMAN. Yes, sir. That is what is proposed.

Mr. DUNN. We had a—of money that we put up a few years ago. Is that all gone now?

Mr. BOWMAN. Yes, sir. That was a great influx of money that really took away the backlog. The problem is, it is already back up to approximately \$500 million on the priority one list. If you go down beyond that, it is almost \$1.2 million.

You know, that is why we are asking for \$250 million, to at least hit half of that priority one group to stay up current.

Mr. DUNN. I am going to ask you to share with us, either off line or in our next meeting here, if we are going to do some more of these hearings, I would sort of like to hear a plan for all of it, not just a year by year, \$250 million a year, every year kind of—where are we going? Where do we think we need to be? When do we think we need to be there to address specifically the burgeoning problem of dementia in all of its presentations.

Can you—Mr. Bowman, again, can you give us an update on the implementation of the state veteran home and adult day health care improvement act?

Mr. BOWMAN. Yes. Actually, we just—

Mr. DUNN. It is like 2 years old, though, I guess.

Mr. BOWMAN. Yes, sir. At our annual convention, or winter conference just recently, we met with representatives from the VA about rate setting. Part of that discussion was very positive because as we move into permanent rate setting, it is going to really, I think, provide an impetus for other facilities and programs that have not been involved in that to expand to that, because everyone sees the value of adult day health care, because not only does it give respite to families, but most importantly, it gets back to this non-institutional care for those veterans that can remain at home, be a valuable member and engaged in their family, come and get the care that they need, and that includes more than just coming in for meals and, say, bingo. It also, under that medical model, allows for care that they would otherwise have to go to multiple appointments at various providers to get that care for.

It is a—I think we are going to see an increase in that. We already have three states that since that meeting have indicated interest, and those are in Boise, Ogden, Utah, and Philadelphia. We are going to see more. There was a lot of interest in that. I think that is going to help when we talk about the continuum of care expansion.

Mr. DUNN. I look forward to continuing that conversation. With that, Madam Chair, I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn. I have a few more questions, and if you do, I will—you certainly chime in. Mr. Atizado, I wanted to ask you, too, about the medical foster homes, and the veteran directed care program, and just in terms of your membership. Do they like these programs? Do they need to be expanded?

Mr. ATIZADO. Yes on both. Our members are very much satisfied when they end up residing in a medical foster home. I have had the opportunity to talk to a handful of them across the state, and they are extremely happy with the small home like setting, being able to still be relatively independent and not feel like they are in an institution.

The problem for a couple of them is that they have to pay for this out of pocket, and we are hopeful that the subcommittee and the full committee, like they have done in the last two congresses, will pass that bill that will allow VA to pay for that care, so they do not have to worry about impoverishing themselves for a benefit that otherwise, you know, had they decided to take up their nursing home benefit, it would cost VA more to do that.

With regards to the veteran directed care program, that is a fantastic program that our—I can not seem to turn left or right without somebody asking when it is coming to their facility. For example, Congresswoman Brownley, in the state of California, only one VA facility runs a veteran directed care program: San Diego. It is a fantastic program. ACL, the administrative community living, actually went down and visited San Diego and their program down there, and is highlighting that.

Mr. Dunn, Florida is doing much better. I think only one facility in Florida does not have a veteran directed care program. That requires a partnership between the facility and basically each county in its market area. Now, if a facility director does not feel it is important and the local clinicians do not have that support, the program is not going to exist or it is not going to expand.

It is a fantastic program, like I said. It allows a veteran to control the services they get. VA assesses them for needs. They monetize that need. Their partnership with American Ambulance Associations (AAAs), AOCs, they are state funded entities, help them identify those services in their community. It could be their neighbor.

You know, if we are talking about a health care workforce issue with regards to nurse assistance, and home maker, and home health aids, this is a great program to expand, because it relies on existing people in the community already.

My biggest issue with in-home care is trust. You are in a very vulnerable situation, asking somebody to come and help you with their basic living skills. When you have a stranger coming in day after day, it can wear on you. That is why I think there is also a lot of turnover in that industry. We think our members think veteran directed care is one of the programs that really should be available at every VA facility.

Ms. BROWNLEY. You mentioned California having one program, Florida, I think you said, does not have any whatsoever. Can you—

Mr. ATIZADO. No, I am sorry, Florida is very much better. Only—

Ms. BROWNLEY. You are doing well.

Mr. ATIZADO.—one facility does not have the program.

Ms. BROWNLEY. Your leadership has been extraordinary, Dr. Dunn.

Can you give me a sense, though, of what it looks like across the country?

Mr. ATIZADO. The veteran directed care program?

Ms. BROWNLEY. Yes.

Mr. ATIZADO. I think about 69 out of 170 facilities actually have it. As I mentioned, just because a facility has it, it does not mean they can cover all the veterans in their market area.

Ms. BROWNLEY. Yes.

Mr. ATIZADO. What we are hoping is, because the MISSION Act that Congress passed a couple years ago, allows VA to use a veteran care agreement. Before it was a legal grey area, but the veteran care agreement allows now VA to go full bore. There is no legal barrier to this or liabilities.

It really comes to the local facility being responsive to the veterans in their market area. We can only ask so much as veteran patients for the facility to have these programs. If there is a little bit more pressure and leadership support, I think we can actually grow this program to where it needs to be.

One of the key things I wanted—I was hoping Mr. Sablan would still be here, because I think this would be very good in rural areas. I think it would be extremely useful, and in particular, the situation that he raised.

Ms. BROWNLEY. Yes. Thank you for that. Mr. Bowman, I would like to work with you with some of the issues that you have, you know, brought up, and certainly the grant program, but the issue around psychological services, the accreditation piece. You know, I would really like to work with you on that.

The one question that I have for you is that the—according to the Center for Disease Control and Prevention (CDC), infection rates of sexually transmitted diseases are climbing exponentially among Americans 45 and older. I am just wondering, is this something that you see as a significant issue in your homes across the country?

Mr. BOWMAN. Anecdotally, no. That has not really hit on our radar yet. I am not say it is not out there in pockets, but it has not hit our radar.

Ms. BROWNLEY. Okay. There is no data on that, then, from your perspective?

Mr. BOWMAN. No.

Ms. BROWNLEY. Then last, I would just say, you know, you kindly said to Dr. Dunn, we can get that information for you. When I asked the question about data, you know, you are like, “Well, you can get those from the various state homes.” So—

Mr. BOWMAN. I—

Ms. BROWNLEY.—I am feeling a little rejected.

Mr. BOWMAN. I apologize. Meaning that the state homes had those numbers. I will be glad to assimilate as much of that as I can and get it to you, ma’am. Sorry for—

Ms. BROWNLEY. Thank you very much. Thank you very much. Dr. Dunn?

Mr. DUNN. Thank you, Madam Chair. I do not have anymore questions. I will say that I think this is an important hearing. I think that this is a big subject and everybody has a lot of focus on it.

We work better when we have more information. I have some of the information. You heard both of us say that we want more information, you know, what we need, but also what it costs, and what we can do efficiently. That matters a lot to us. I mean, we really are all pulling in the same direction on this one.

I will say anecdotally, since you brought up the subject, no urologist will let this go by—I am a urologist by specialty training, and I hear anecdotally about all of these elder population epidemics of STDs. In my specialty, we would tend to hear about that or know about that. In one of the areas that my group took care of, literally the entire urological care for the Villages, famous area in Florida, right, and all the rumors about exploding STDs down there, really they are for fun. They are salacious rumors, but that does not match the facts on the ground.

I will just say that is—for what it is worth. It is in the congressional record now. I yield back.

Ms. BROWNLEY. Thank you. Thank you, Dr. Dunn. We will not end the committee hearing on that particular note, although you are right. I thank the panelists for being here and I, too, believe that this is a very important topic. I will be anxious to—we will try to schedule another hearing when the elderly strategic plan comes up.

I hope some of the comments that were made today, you will take home, Dr. Boyd, in terms of that overall discussion. I know Dr. Stone believes that we should be, you know, shifting more from institutional to non-institutional care, but seeing a strategic plan for the first time obviously is very, very important. You know, this is a priority for me. It is a priority for Dr. Dunn. We are going to be diving, taking a deeper dive into this issue. I look forward to, you know, making some recommendations with regards to policy changes as we move forward.

The statutory issue, I think is one that really does need to be addressed. I believe that state nursing homes need to play a larger part, particularly in meeting sort of regional needs. I think from the sounds of it, state veteran homes have a pretty good reputation across the country.

Anyway, I thank you all for being here. Thank you for your testimony and answers to our questions. With that, Dr. Dunn, if you have any closing comments, it is—you are on.

Mr. DUNN. Thank you very much.

Ms. BROWNLEY. Well, thank you all for being here. This meeting is adjourned.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Teresa Boyd

Good morning Madam Chairwoman, Ranking Member Dunn, and distinguished Members of the Subcommittee. I appreciate the opportunity to discuss VA long-term care and Veterans' choices for care as they age or face catastrophic injuries or illnesses. I am accompanied today by Dr. Beth Taylor, Chief Nursing Officer; Dr. Scottie Hartronft, Executive Director, Office of Geriatrics and Extended Care (GEC); and Dr. Elyse Kaplan, Deputy Director, Caregiver Support Program.

Introduction

VA is committed to optimizing the health and well-being of Veterans with multiple chronic conditions, life-limiting illness, frailty or disability associated with chronic disease, aging, or injury. GEC's programs maximize each Veteran's functional independence and lessen the burden of disability on Veterans, their families, and caregivers. VA believes that these programs also honor Veterans' preferences for health and independence in the face of aging, catastrophic injuries, or illnesses by advancing expertise and partnership. For the increasing numbers of Veterans, of any age, facing the challenges of serious chronic diseases and disabling conditions, VA GEC offers a comprehensive spectrum of geriatrics, palliative care, and long-term services and supports (LTSS) that surpasses all other US health care systems by providing services in the home, community, clinics, hospitals, and nursing facilities. The overarching goal of GEC is to meet these Veterans' long-term care needs in the least restrictive setting through access to options that honor their choice while promoting their optimal independence, health, and well-being. Our strong history of innovation continues, advancing models of care, practices, training, and partnerships that improve care not only for Veterans but for all Americans.

An Aging Population

Nearly 50 percent of the more than 9 million Veterans currently enrolled in VA's health care system are 65 years old or older. Between 2018 and 2028, the number of enrolled Veterans aged 75 and older is projected to increase by 46 percent, from 2 million to an estimated 2.9 million. During the same timeframe, the number of enrolled Veterans under age 75 is projected to decrease by 14 percent. The number of Veterans aged 85 and older enrolled in the system has increased almost 300 percent between 2003 and 2018 and is projected to surge close to 500 percent by 2038.

As Veterans age, approximately 80 percent will develop the need for LTSS. Most of this support in the past has been provided by family members, with women providing most of the care. The average number of potential family caregivers per older adult in America is currently 7, but that number will likely decline to 4 in 2030. The availability of these potential family caregivers can be jeopardized due to work responsibilities outside the home. Moreover, many Veterans are divorced, have no children, are estranged from their families, or live long distances from family members. In one of our programs we care for some of our most medically complex and disabled Veterans, and although half are married, one-third of their spouses have chronic disabling conditions. This lack of a strong family caregiver is especially true for the increasing numbers of women Veterans who are at higher risk for needing LTSS due to their longer life expectancies and greater risk of disability than men at any age.

The aging of the Veteran population has been growing rapidly and represents a greater proportion of the VA patient population than observed in other health care systems. Addressing the needs of these Veterans was recognized as a priority by 1975, which led to the development of 20 currently existing Centers of Excellence called Geriatric Research, Education, and Clinical Centers (GRECC) within VA. Where available, these GRECCs have served as an incubator for research into health and health systems relevant to older Veterans and spawned innovative clinical programs that have been shown to optimize Veterans' function; prevent unnecessary and costly nursing home admissions and hospitalizations; and reduce un-

wanted and unnecessary tests and treatments, thereby reducing health care costs. Finally, GRECCs continue to address the geriatric workforce shortage, providing thousands of students training hours and exposure to care for older adults. The advances from GRECCs and other GEC innovations continue to benefit not only Veterans, but all Americans.

Geriatrics and Extended Care Programs In-depth

GEC's programs include a broad range of LTSS that focus on facilitating Veteran independence, enhancing quality of life, and supporting family members and Veteran caregivers. Many of the services provided via these programs are not available in any other health care system. The 4 categories of LTSS are: Home and Community-Based Services (HCBS); Facility-Based Care; geriatric services provided in outpatient clinics and hospitals; and Hospice and Palliative Care in all settings.

Home and Community-Based Services

HCBS supports independence by allowing the Veteran to remain in his or her own home as long as possible. More than one service can be received at a time. These programs include, but are not limited to, the following:

- **Adult Day Health Care:** This is a day program provided to Veterans for social activities, peer support, companionship, and recreation. The program is for Veterans who need skilled services, case management, and help with activities of daily living. Most Adult Day Health Care is purchased from community providers, but some VA medical centers (VAMC) also provide this service within their facilities.
- **Home Based Primary Care (HBPC):** Through this program, Primary Care is provided to Veterans in their homes. A VA physician leads the interdisciplinary health care team that provides the comprehensive longitudinal health care. This evidenced-based program is for Veterans who have complex health care needs and routine clinic-based care is not effective.
- **Homemaker/Home Health Aide:** A trained person comes to a Veteran's home and helps the Veteran take care of him or herself and their daily activities. These aides are not nurses, but they are supervised by a registered nurse who helps assess the Veteran's daily living needs.
- **Palliative and Hospice Care:** This program offers comfort measures that focus on relief of suffering and optimizing quality of life.
- **Respite Care:** This service pays for a person to come to a Veteran's home or for a Veteran to go to a program while their family caregiver takes a break. Thus, the family caregiver is allowed time away without the worry of leaving the Veteran alone.
- **Skilled Home Health Care:** These are mostly short-term health care services provided to Veterans if they are homebound or live far away from a VAMC. The care is delivered by Medicare or Medicaid-certified community-based home health agencies.
- **Telehealth:** This service allows the Veteran's physician or nurse to monitor their medical condition remotely using monitoring equipment. Veterans can be referred to a care coordinator for Home Telehealth services by any member of their care team. Home Telehealth is approved by a VA provider for Veterans who meet the clinical need for the service.
- **Veteran-Directed Care:** This program gives Veterans of all ages the opportunity to receive the HCBS they need in a consumer-directed way. Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver. As part of this program, Veterans and their caregiver have more access, choice, and control over their long-term care services.

Adult Day Health Care, HBPC, Homemaker/Home Health Aide, Palliative and Hospice Care, Respite Care, and Skilled Home Health Care are all part of the standard medical benefits package all enrolled Veterans with clinical needs receive.

While HCBS continues to improve care for Veterans, it has also helped reduce costs for the Department. VA financial obligations for nursing home care in Fiscal Year (FY) 2019 reached \$6.3 billion. The number of Veterans with service-connected disabilities rated 70 percent or more, for whom VA is required to pay for needed nursing home care, is projected to increase from 1.9 million to 3.1 million Veterans between 2018 and 2028. Therefore, if nursing home utilization continues at the current rate among Veteran enrollees, without consideration of inflation, the costs to

VA for providing nursing home care for enrolled Veterans are expected to significantly increase.

Fortunately, evidence has shown appropriate targeting and use of the programs and services available through GEC, especially those services that are provided in HCBS, can reduce the risk of preventable hospitalizations and delay or prevent nursing home admissions and their associated costs substantially. Therefore, VA has increased access to HCBS over the last decade. There is an urgent need to accelerate the increase in the availability of these services since most Veterans prefer to receive care at home, and VA can improve quality at a lower cost by providing care in these settings.

States have found that through their Medicaid programs, they have been able to reduce costly nursing home care by rebalancing their expenditures for LTSS between institutional and home and community-based settings. As of 2016, national Medicaid expenditures for home and community-based services for the population most similar to VHA users, older adults and people with physical disabilities, represent 45 percent of total LTSS – up from 17 percent 20 years prior. Comparable personal care services (Home maker/Home Health Aide, Respite, and Adult Day Health Care) accounted for 10.6 percent (\$930 million) of VA's LTSS obligations in Fiscal Year 2019. The total budget of all HCBS, including personal care services, accounted for 31 percent of the LTSS budget obligations in Fiscal Year 2019. Current annual per Veteran costs for nursing home care are 8.6 times the annual costs for HCBS within VA.

Residential Settings are supervised living situations that provide meals and assistance with activities of daily living. These settings require Veterans to pay their own rent, but HBCS can be provided if the Veteran has certified needs and is enrolled in VA's health care system. Medical Foster Homes (MFH) fall within this category. MFHs provide an alternative to nursing homes in a personal home at substantially lower costs. VA provides program oversight and care in the home through HBPC, while the Veteran pays on average \$2,400 per month for room, board, and daily personal assistance. MFHs currently operate in 45 states providing care for over 1,000 Veterans each day at a significant cost savings as compared to care provided in community nursing homes. Additionally, Veterans express high levels of satisfaction from care provided through MFH, but many are limited from MFH because of the costs to the Veteran.

In the Department's Fiscal Year 2021 budget request, VA submitted a legislative proposal to require VA to include in the program of extended care services the addition of care in MFHs; this would apply to Veterans for whom VA is required to provide nursing home care.

Facility-Based Care

Nursing homes are settings in which skilled nursing care, along with other supportive medical care services, is available 24 hours a day. All Veterans receiving nursing home care (NHC) through VA, whether provided in one of the 135 VA-operated Community Living Centers (CLC), in a State Veterans Home (SVH), or purchased by contract or agreement in one of the over 2,000 available community nursing homes (CNH), must have a clinical need for that level of care. VA strives to use NHC when a Veteran's health care needs cannot be safely met in the home. Veterans who have service-connected disabilities rated at 70 percent or greater and need NHC for service-connected conditions or are being placed in a nursing home by VA staff for the delivery of inpatient hospice care have mandatory eligibility for NHC. Veterans with mandatory nursing home eligibility can be provided care in a VA CLC, an SVH, or in a private nursing home under contract with VA. Consideration is given for Veterans' preferences based upon clinical indication and/or family/Veteran choice, when possible. Since 2012, each year more Veterans chose to die in VA CLC hospice beds than in all of VA Acute and Intensive Care Unit deaths combined. These CLC hospice beds provide specialized support for terminally ill Veterans in their final weeks and surveys of these Veterans' family members reveal high satisfaction with this care. Veterans without mandatory nursing home eligibility, a population that makes up the majority of Veterans, receive care on a resource available basis. If these Veterans are admitted to the CNH Program, placement at VA expense is generally limited to 180 days. Extensions are available in certain circumstances. More non-mandatory Veterans who need nursing home care usually receive that care in VA CLCs rather than in private nursing homes at VA expense.

VA maintains strong, working relationships with every State in the oversight and payment of Veterans' care at SVHs. Through this effort, states provide care to eligible Veterans across a wide range of clinical care needs through NHC, domiciliary care, and adult day health care programs. VA can provide: construction grant fund-

ing for construction and renovation of the State home; continuing operating funds for eligible Veterans through a grant and per diem program; and ongoing quality monitoring to ensure Veterans in SVHs receive high quality care. Currently, there are 157 SVHs across all 50 states.

Ambulatory Care and Inpatient Acute Care Programs

Finally, GEC offers Ambulatory Care programs (including Geriatric Patient-Aligned Care Teams (GeriPACT)); Inpatient Acute Care Programs (including Geriatric Evaluation and Management); and a variety of dementia and delirium programs. GeriPACT clinics provide longitudinal, interdisciplinary team-based outpatient care for high-risk, high-utilization, and predominantly (but not exclusively) elderly Veterans. The teams have enhanced expertise for managing Veterans whose health care needs are particularly challenging due to multiple chronic diseases, co-existing cognitive and functional decline, as well as psychosocial factors. GeriPACT integrates and coordinates traditional ambulatory and institution-based health care services with a variety of community-based services and strives to optimize independence and quality of life for these particularly vulnerable Veterans in the face of their multiple interacting cognitive, functional, psychosocial, and medical challenges. GeriPACT panel sizes are one-third smaller than regular PACT teams and have a social worker and a pharmacist as core members. By helping Veterans maintain function, preventing unnecessary hospitalizations, nursing home admissions, and unwanted tests and procedures, the total costs of care for targeted high-risk Veterans are about 15 percent lower when they are managed in GeriPACT versus being managed by regular Primary Care Patient Aligned Care Teams. Currently, only about half of VAMCs have GeriPACT, and VA is working to expand this program to larger Community-Based Outpatient Clinics.

Caregiver Support Program

Caregivers are eligible for a host of VA services including those offered under the Program of General Caregiver Support Services (PGCSS). These general services are available to support all caregivers, when the Veteran is enrolled for VHA healthcare regardless of illness or injury. In addition to the general services offered under the PGCSS, caregivers in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) may also receive a monthly stipend, beneficiary travel, mental health counseling, enhanced respite services, and health insurance, if applicable. Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, we are working to give more family caregivers access to PCAFC and support them as they care for Veterans of all eras. Currently, PCAFC is only available to eligible Veterans injured in the line of duty on or after September 11, 2001. Prior to expanding eligibility for PCAFC, VA must upgrade its information technology (IT) system and implement other improvements to strengthen the program.

The Caregiver Support Program's shoulder-to-shoulder work with VA's Office of Information and Technology has realized the successful launch of a replacement IT solution, termed the Caregiver Record Management Application (CARMA). This solution supports the administrative needs of PCAFC; PGCSS; and the Caregiver Support Line. The initial phase CARMA was successfully released in October 2019, with a follow up release in December 2019 to transition the remaining functionality from the former system to CARMA. Further functionality enhancement to CARMA in Fiscal Year 2020 will prepare the program for expansion—automating stipend payments, improving functionality that supports PCAFC processes, and solidifying integrations with key VA systems.

In support of achieving the goals of program stabilization and expansion required by the VA MISSION Act of 2018, a strategic and expedited staffing plan was initiated to ensure a strong foundational infrastructure on which to expand the PCAFC program. By August 2019, over 680 positions had been approved for hire. This hiring phase included establishing facility staff such as program coordinators in the field for both PCAFC and PGCSS, as well as establishing Veterans Integrated Service Network (VISN) Leads and VISN Clinical Eligibility and Appeals teams. By the end of January 2020, 51 percent of those positions had already been filled. Completion of full staffing is targeted to occur in time for program expansion in the Summer of 2020.

Conclusion

VA's various long-term care programs provide a continuum of services for older Veterans designed to meet their needs as they change over time. Together, they have significantly improved the care and well-being of our Veterans. These gains would not have been possible without consistent Congressional commitment in the

form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for our Veterans and their families. Madam Chair, this concludes my testimony. My colleague and I are prepared to answer any questions.

Prepared Statement of Nikki Clowers



United States Government Accountability Office

Testimony

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Committee on Veterans' Affairs, House
of Representatives

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VA HEALTH CARE

**VA Faces Challenges in
Meeting Demand for Long-
Term Care**

Statement of A. Nicole Clowers, Managing Director,
Health Care

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent report on the challenges faced by the Department of Veterans Affairs (VA) in meeting veterans' growing demand for long-term care.¹ Veterans—like millions of other Americans—rely on long-term care to help meet their health and personal care needs. Long-term care can address a broad spectrum of needs, from providing occasional help around the house to extensive, round-the-clock clinical care. VA provides or pays for long-term care through a range of institutional and noninstitutional programs for eligible veterans. Institutional programs, such as nursing homes, typically provide acute skilled nursing care in a residential facility.² Noninstitutional programs, such as the Home-Based Primary Care program, provide care to veterans in their homes or communities.³ In fiscal year 2018, VA provided or paid for long-term care for over 500,000 veterans.

As one of the largest health care systems in the United States, VA faces challenges similar to other health care providers when seeking to meet the growing need for long-term care as the U.S. population ages – for example shortages in nursing assistants and home health aides that are critical for supporting long-term care programs. VA recognizes it faces challenges meeting the demand for long-term care and has taken some steps to address these challenges in its strategic planning process, for example by proposing to expand access to long-term care services through telehealth.

My testimony today highlights key findings from our February 2020 report, which described the (1) use of and spending for VA long-term care, and

¹GAO, *VA Health Care: Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand*, [GAO-20-284](#) (Washington, D.C.: Feb. 19, 2020).

²For more information on VA nursing home care, see GAO, *VA Nursing Home Care: VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website*, [GAO-19-428](#) (Washington, D.C.: July 3, 2019).

³These programs—collectively, all 14 of VA's Long-Term Services and Supports programs—comprise the majority of VA's obligations for long-term care. Although not within the scope of this testimony, VA also may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support program, and disabled veterans also may be eligible for increased compensation benefits from the Veterans Benefits Administration. For more information on the Caregiver Support program, see GAO, *VA Health Care: Actions Needed to Improve Family Caregiver Program*, [GAO-19-618](#) (Washington, D.C.: Sept. 16, 2019).

(2) challenges VA faces to meet veterans' demand for long-term care and examines VA's plans to address those challenges. We made three recommendations in our report aimed at strengthening VA's efforts to address long-term care challenges. VA concurred with our recommendations.

To describe the use of and spending for VA long-term care, we reviewed VA data on the utilization of and obligations for long-term care for fiscal years 2014 through 2018 and projections of utilization and expenditures developed by VA's Enrollee Health Care Projection Model (EHCPM) for fiscal years 2017 through 2037.⁴ To discuss the challenges VA faces in meeting veterans' demand for long-term care, we reviewed relevant VA documents and interviewed VA officials about VA's capacity to provide long-term care, including officials from VA's Geriatrics and Extended Care office (GEC) which oversees the long-term care programs, and officials from the Office of Policy and Planning. Further details on our scope and methodology are included in our report. The work on which this statement is based was performed in accordance with generally accepted government auditing standards.

Background

VA provides or pays for long-term care—ranging from assistance with dressing and bathing to clinical care for spinal injuries or dementia—through three institutional and 11 noninstitutional programs. (See fig. 1 for a list of VA's institutional and noninstitutional long-term care programs and app. I for brief descriptions of these programs.)

⁴VA spending data for fiscal years 2014 through 2018 is reported in terms of obligations. VA officials told us that these data do not include non-veterans and may differ from data included in VA's congressional budget justification for a variety of reasons and that VA used a standard definition of services for all years. See Department of Veterans Affairs, *Volume II, Medical Programs and Information Technology Programs, Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations* (Washington, D.C.: Mar. 11, 2019).

VA projection data for fiscal years 2017 through 2037 do not include projections for State Veterans Homes or State Adult Day Health Care programs and were provided by the Veterans Health Administration's Office of Enrollment and Forecasting. Projected spending in this data is reported in terms of expenditures. These projections use base year 2017 data from a variety of sources that may differ from actual units and obligations that year.

Figure 1: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs

 INSTITUTIONAL PROGRAMS	 NONINSTITUTIONAL PROGRAMS
<ul style="list-style-type: none"> VA Community Living Centers Community Nursing Homes State Veterans Homes 	<ul style="list-style-type: none"> Homemaker Home Health Aide Home-Based Primary Care Purchased Skilled Home Care Home Telehealth Community Adult Day Health Care VA Adult Day Health Care State Home Adult Day Health Care Home Hospice Care Home Respite Care Community Residential Care Spinal Cord Injury and Disability Home Care

Source: GAO analysis of VA documents. | GAO-20-463T

Notes: We include all 14 of VA's Long-Term Services and Supports programs, which represent the majority of VA's obligations for long-term care, and for the purposes of this report, we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration.

VA's long-term care programs serve over 500,000 veterans with a wide range of characteristics and needs. Further, certain Community Nursing Homes, Adult Day Health Care, and Hospice and Respite Care programs have specially trained staff to serve veterans with dementia, and the Spinal Cord Injury and Disability Home Care program and certain VA Community Living Centers are equipped to serve veterans needing ventilator care.

All veterans enrolled in the VA health care system are eligible for VA's basic medical benefits package, which includes coverage for certain

institutional and noninstitutional long-term care services.⁵ A veteran's eligibility for fully or partially covered nursing home care is determined by the veteran's priority for care, which is generally based on the veteran's service-connected disability status. VA must cover the full cost of nursing home care for veterans who need this care for a service-connected disability and for veterans with service-connected disabilities rated at 70 percent or more.⁶ Veterans' placement into particular long-term care programs may depend on their clinical needs, disability ratings, preferences, and the availability of VA programs. When funds are limited, the agency may prioritize program placement based on veterans' service-connected disability ratings. Decisions about which long-term care programs may be the best fit are made at the VA medical center (VAMC) level between VA providers, veterans, and their families.

Utilization of and Spending for VA Long-Term Care Have Increased in Recent Years and Are Projected to Increase

As we reported in February 2020, VA data shows that utilization of and spending for VA long-term care programs generally increased from fiscal years 2014 through 2018. Specifically, the number of veterans receiving care in VA's long-term care programs increased 14 percent from fiscal years 2014 through 2018, from 464,071 to 530,327 veterans, while spending grew 33 percent from \$6.8 billion to \$9.1 billion. Further, we found that VA projects utilization and expenditures for long-term care to increase for most of the programs included in VA's EHCPM from fiscal years 2017 through 2037.⁷ Specifically, over that time period VA's model projects the following:

- Utilization of long-term care—in terms of various VA workload units—is projected to grow in one of the two institutional programs and nine of the 10 noninstitutional programs included in the EHCPM from fiscal years 2017 through 2037.
- Spending, which VA reports as expenditures, is projected to more than double from fiscal years 2017 through 2037, increasing from \$6.9

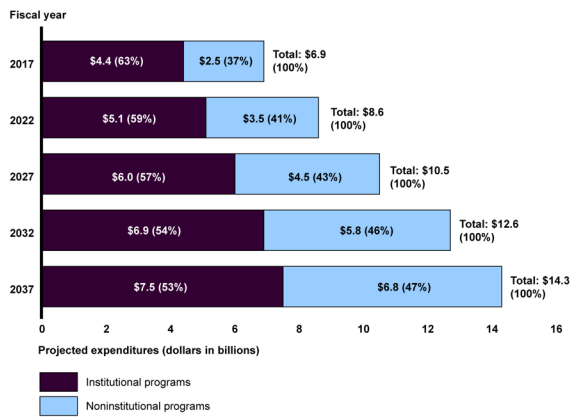
⁵38 C.F.R. §§ 17.36(a), 17.38(a)(1) (2019). See also U.S. Department of Veterans Affairs, *Federal Benefits for Veterans, Dependents and Survivors* (VA Pamphlet 80-18-01 P94663), 2018 Edition.

⁶This requirement expires on September 30, 2020, and is subject to the availability of appropriations. 38 U.S.C. § 1710A(a). Additionally, VA may cover this care for other veterans subject to certain considerations, such as available resources and capacity. See generally 38 U.S.C. § 1710.

⁷The EHCPM does not project utilization or expenditures for state-operated programs, specifically, the State Veterans Homes and the State Adult Day Health Care programs.

billion to \$14.3 billion.⁸ (See fig. 2.) VA also projects that the proportion of expenditures for institutional long-term care will decrease from 63 percent to 53 percent while the proportion of noninstitutional program expenditures is projected to grow from 37 percent to 47 percent in that same time period.

Figure 2: Projected Expenditures for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2017 through 2037



Source: GAO analysis of projected VA expenditure data. | GAO-20-463T

Notes: These long-term care programs include those that VA projects using its Enrollee Health Care Projection Model based on fiscal year 2017 data. This model includes 12 of the VA's 14 Long-Term Services and Supports programs, excluding State Veterans Homes and State Home Adult Day Health Care. Totals may not sum due to rounding.

According to VA officials, these projected increases are due to a variety of factors, including that VA plans to continue expanding the availability of noninstitutional care, and plans on providing care to an increasing number of aging veterans and veterans rated in the highest service-

⁸Part of this increase reflects inflation over time. Using projections from the Congressional Budget Office, for example, prices are expected to rise by 49 percent during the same period.

connected disability groups. Officials also noted that expanding veterans' access to noninstitutional care programs is less costly than institutional care, and veterans prefer to delay or reduce the amount of institutional care they receive. VA's strategies to meet the growing demand for long-term care are operationalized by GEC at the program level and implemented at the regional and VAMC level.

VA Has Identified Several Key Challenges to Meeting the Demand for Long-Term Care, but Lacks Measurable Goals for Addressing Them

In our February 2020 report, we found that VA faces a number of key challenges in meeting veterans' growing demand for long-term care: workforce shortages, geographic alignment of care, and difficulty meeting veterans' needs for specialty care.

Table 1: VA Identified Challenges to Meeting Department of Veterans Affairs' (VA) Projected Demand for Long-Term Care

Key challenge	Description
Addressing workforce shortages	<ul style="list-style-type: none"> VA officials described nationwide shortages of geriatricians and palliative care providers—provider shortages that will affect VA's ability to provide long-term care services to veterans in the future. VA also faces shortages in other workforce areas, such as nursing assistant and health technician positions that have contributed to waiting lists. For example, according to VA officials, staffing challenges were the key factor creating a waitlist of 1,780 veterans for the Home-Based Primary Care program.
Aligning care geographically	<ul style="list-style-type: none"> VA faces challenges aligning its services (provided or purchased) with where veterans live, including providing care for veterans living in rural areas. For example, according to VA officials, veterans have moved away from the Northeast and to the South, and that VA now has too many long-term care beds in the Northeast and too few in the South.
Meeting needs for specialty care	<ul style="list-style-type: none"> VA faces challenges finding appropriate long-term care settings for veterans with certain specialty care needs such as dementia, behavioral issues, and ventilator care.

Source: GAO analysis of VA documents and interviews. | GAO-20-463T

While GEC recognizes and has taken some steps to address the challenges it faces, it has not established measurable goals for its efforts to address these three key challenges:

- GEC has not established measurable goals to address workforce shortages, such as staffing targets to address the waitlist for the Home-Based Primary Care program.

-
- GEC has not established measurable goals for its efforts to address the geographic alignment of care, such as specific targets for providing long-term care within the Home Telehealth and Veteran Directed Care programs.
 - GEC has not established measurable goals for its efforts to address difficulties meeting veterans' needs for specialty care, such as specific targets for the number of available ventilators or the number of caregivers educated to help veterans with dementia.

As we noted in our report, without measurable goals, VA is limited in its ability to better plan for and understand progress towards addressing the challenges it faces meeting veterans' long-term care needs. To address this issue, we recommended that GEC develop measurable goals for its efforts to address these key long-term care challenges. VA concurred with this recommendation.

In our February 2020 report we also found that VA had identified, but had not planned to take steps to fully address, challenges at the VAMC level that affect VA's ability to meet veterans' long-term care needs:

- VA identified that VAMCs do not have a consistent approach to managing VA's 14 long-term care programs. At VAMCs where there are not GEC staff, long-term care programs could be run by one or more departments within the VAMC, for example the Nursing department or the Social Work department. GEC officials told us that this fragmentation hinders standardization and the ability to get veterans the appropriate care.
- VA also identified that VAMCs use different approaches to assess the amount of noninstitutional long-term care services veterans need. While GEC has developed a tool to improve the consistency in these determinations, VA has not required the tool be used in all VAMCs, as of October 2019. As a result, decisions about the amount of services veterans receive may vary by VAMC.

To address these issues, we recommended that GEC leadership set time frames for and implement (1) a consistent GEC structure at the VAMC level and (2) VAMC-wide standardization of the tool for assessing noninstitutional program needs of veterans. VA concurred with our recommendations.

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

**GAO Contacts and
Staff
Acknowledgments**

If you or your staff have any questions about this testimony, please contact A. Nicole Clowers, Managing Director, Health Care at (202) 512-7114 or clowersa@gao.gov or Sharon Silas, Director, Health Care, at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition to the contacts named above, key contributors to this statement were Karin Wallestad (Assistant Director), Luke Baron (Analyst-in-Charge), Summar C. Corley, and Laurie Pachter. Also contributing to the underlying report for this statement were Kye Briesath, Vikki Porter, Corinne Quinones, and Jennifer Rudisill.

Appendix I: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Program Descriptions

Table 2: Department of Veterans Affairs' (VA) Institutional Long-Term Care Program Descriptions

Program	Description
VA Community Living Centers	Provide 24-hour skilled nursing care in VA-owned homes, and may also provide domiciliary care, such as for mental health or substance abuse.
Community Nursing Homes	Provide 24-hour skilled nursing care in public or privately owned homes that VA contracts with to provide this care.
State Veterans Homes	Provide 24-hour skilled nursing care in homes that are owned and operated by states.

Source: GAO analysis of VA documents. | GAO-20-463T

Notes: We include three of VA's 14 Long-Term Services and Supports programs that represent its institutional programs for eligible veterans, and for the purposes of this statement we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. These programs are not reflected in this table.

Table 3: Department of Veterans Affairs' (VA) Noninstitutional Long-Term Care Program Descriptions

Program	Description
Homemaker Home Health Aide	Trained aides come to the home to help veterans with activities of daily living through a VA-contracted organization. Alternatively, the Veteran Directed Care program provides veterans with a budget for care.
Home-Based Primary Care	A health care team, supervised by a VA physician, provides health care services to veterans with complex needs.
Purchased Skilled Home Care	Provides nursing care and other health services by a VA-contracted community-based agency for veterans who live far from VA facilities.
Home Telehealth	Allows physicians or nurses to monitor a veteran's medical condition remotely and to talk with the veteran to discuss care.
Adult Day Health Care ^a	Provides activities and support for veterans who need help with activities of daily living, who are isolated, or have caregivers in need of relief. This care may be provided in VA, state, or community programs.
Home Hospice Care	Provides comfort care for veterans and family in home, clinic or inpatient settings for veterans with less than 6 months to live.
Home Respite Care	Provides short-term care at home or at an adult day care program when family caregivers need a break.
Community Residential Care	Provides 24-hour care, room and meals in family care homes, assisted living homes or medical foster homes for veterans who cannot live alone because of medical or mental health conditions.
Spinal Cord Injury and Disability Home Care	Care centers provide primary and specialty care for veterans who have spinal cord injuries, and local teams provide care close to veterans' homes.

Source: GAO analysis of VA documents. | GAO-20-463T

Notes: We include 11 of VA's 14 Long-Term Services and Supports programs that represent its noninstitutional programs for eligible veterans, and for the purposes of this statement we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. These programs are not reflected in this table.

^aFor the purposes of this table, we condensed the three Adult Day Health Care program descriptions into one entry.

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Prepared Statement of Adrian Atizado

Madam Chair and Members of the Subcommittee:

Thank you for conducting this critical oversight hearing and calling attention to the essential, but often overlooked, role of the long-term services and supports (LTSS) provided by or sponsored by the Department of Veterans Affairs (VA).

As a predominantly hospital-based system three decades ago, about 95 percent of VA's LTSS spending went toward furnishing nursing home care. But the VA health care system was about to be transformed in 1996, through Public Law 104-262, the Veterans' Health Care Eligibility Reform Act. This law changed the operating environment in which VA LTSS was being delivered to veterans. This law pushed VA health care toward a more holistic approach in providing service-connected disabled veterans a lifetime of care, but did not appreciably alter veterans' eligibility for VA LTSS.¹

It was not until 1999 with the Veterans Millennium Health Care and Benefits Act, Public Law 106-117, that the policy regarding VA LTSS was reformed and to a certain extent realigned to the larger VA health care system. This law significantly enhanced the VA's LTSS system, ensuring veterans have access to a full continuum of LTSS by requiring VA furnish nursing home care to any veteran who needs such care for their service-connected disability or if the veteran is service connected 70 percent or greater.

The law provided all veterans using the VA health care system access to home- and community-based services such as adult day health care, respite care and a general category of "non-institutional alternatives to nursing home care." Notably, the law also required VA to look at assisted living as an option for veterans and to determine the effectiveness of different models of all-inclusive care-delivery.²

Because this new public policy was far reaching at the time, Congress added provisions in the law to ensure such transformation would not deplete VA's capacity to provide care to certain subpopulations of veterans or reduce its capacity to provide institutional care. These provisions collectively known as the "Capacity Law," require VA to report and document bed changes to Congress for specific categories of beds, and require that staffing and levels of extended care services remain, at a minimum, at levels provided during Fiscal Year (FY) 1998.³

Despite this dramatic change in public policy, VA was still spending 89 percent of its LTSS budget on institutional nursing home care across three settings: VA community living centers (CLC), which are VA-owned and operated, State veterans homes (SVH), which are state-owned and operated, and community nursing homes (CNH), with which VA contracts for care. Moreover, the landscape outside VA was changing with Medicare and Medicaid policy changes and State program expansion, which reduced nursing home expenditures to just over 70 percent. These changes included greater use of nursing home preadmission screening, expansion of the role of Medicaid home- and community-based (HCBS) waivers, development of assisted living, expansion of new programs such as the Programs of All-Inclusive Care for the Elderly, and changes in medical care delivery through expansion of Medicare and Medicaid managed care.

Just over a decade later and due to our members' frustration, the delegates to DAV's national convention in 2011 passed a resolution urging Congress and VA to develop a strategic plan recognizing the rising cost of institutional care and the limited amount of programs and services that could support aging veterans' preference to remain at home and in their communities. Based on this mandate, our organization worked aggressively with VA to balance its LTSS system by shifting more resources, in the aggregate, from institutional nursing home care to non-institutional services.

A major victory for DAV occurred the following year in 2012, when VA approved a plan in Fiscal Year 2015 to shift resource spending, recognizing the potential that increasing home- and community-based services could reduce nursing home and overall LTSS costs after six years.

By Fiscal Year 2016, VA spent 71 percent of its LTSS budget on institutional care and 29 percent in home- and community-based care and for Fiscal Year 2021, VA plans to spend 67 percent of its LTSS budget on institutional care and 33 percent in home- and community-based services. This shift to honor veterans preference by increasing access to home- and community-based services means 354,995 veterans were served in Fiscal Year 2019—a 21 percent increase over Fiscal Year 2016, when

¹ www.Congress.gov/bill/104th-congress/house-bill/3118

² www.Congress.gov/bill/106th-congress/house-bill/2116

³ Sections 101(c)(1) and 301 of the Veterans Millennium Health Care and Benefits Act, Public Law (Pub. L.) 106-117.

VA served about 285,500 veterans. DAV urges VA to continue this trend and Congress must continue its oversight of the Department's LTSS system, which makes up 11 percent of its proposed budget authority for Fiscal Year 2021.

Today, VA's menu of LTSS includes institutional facility-based care such as VA Community Living Centers; Community Nursing Homes; State Veterans Homes (nursing homes and domiciliaries); Inpatient Hospice; and Inpatient Respite. VA is also authorized to provide a set of home-and community-based services through non-institutional care programs such as Home-Based Primary Care; Home Telehealth; Purchased Skilled Home Care; Home Hospice; VA Adult Day Health Care; Community Residential Care, and Medical Foster Homes. Other home-and community-based services VA is authorized to purchase from community providers include Homemaker and Home-Health Aide; Veteran-Directed Care; Purchased Skilled Home Care; Community Adult Day Health Care; and In-Home Respite Care.

With about 9 million veterans 65 years of age or older, representing about 47 percent of the total veterans' population, demand for these critical programs will continue.⁴ While the total number of senior veterans is projected to decline into the foreseeable future, this population remains the largest age cohort peaking as a percentage of the veterans' population at 48 percent in about 2030. About 3.2 million veterans 65 years of age or older use VA health care services and about half of these veterans (1.6 million) are service connected. In 2019, 425,478 veterans received LTSS from VA. Of these veterans, 27.8 percent were 85 or older. LTSS is not just for aging veterans—16.7 percent of VA's LTSS were provided to veterans less than 65 years of age. Most LTSS users have a high burden of service-connected disability (priority 1 for health care enrollment), catastrophic disability (priority 4) or are low-income (priority 5). About a third (33.2 percent) live in rural areas.⁵

DAV, along with our partners in The Independent Budget,⁶ called for Congress to conduct an oversight hearing into VA's use of home-and community-based services so we are particularly pleased to have this opportunity. As a group, we had also called on Congress to request the Government Accountability Office (GAO) to update its report on veterans' access to home-and community-based services. We are pleased that GAO has made its report available for this hearing and will discuss the findings from its new report below. The last GAO report dedicated to long-term care in VA was published more than a decade ago and recommended improvements in VA's planning and budgeting for non-institutional long-term care that have yet to be addressed.⁷

Before the Gulf Wars began, the VA was increasingly becoming the refuge of older veterans from the World War II era—many were aging with significant disabilities and chronic conditions that required long-term care. VA had begun a major transformation from almost total reliance on inpatient care to one that provided more care on an outpatient basis and in the community. VA and most other long-term care providers long ago shifted the focus of institutional care from serving as a place veterans would go to die to a more transitional and often more intensive role. Many of VA's community living centers (skilled nursing facilities) now offer only subacute and rehabilitative care or specialized respite and end of life care (hospice) for most veterans. Congress mandated that VA allow the highest priority veterans—those with service-connected conditions rated 70 percent or more (priority 1A)—who enter its community living centers to remain as long as they and their families deem necessary.⁸ It should be noted, however, that VA only keeps these Priority 1A veterans an average of 10 days longer than those with nonservice-connected disabilities.

About 80 percent of veterans in VA's CLCs are considered "short-stay" and only 20 percent "long-stay" patients. VA returns veterans with shorter stays to home or transitions them to State or community programs as soon as it deems they have received the maximum benefit from treatment in the CLC. CLCs are generally the most expensive institutional care venue because VA pays the full cost of care for veterans in these homes compared to the other settings and VA CLCs are able to provide acute care that requires higher staffing levels and more specialized equipment. The higher cost also include the overhead costs of being associated with a VA medical center.

⁴Department of Veterans Affairs. VETPOP2016: Table 1L, accessed from va.gov Feb. 18, 2020.

⁵Department of Veterans Affairs. Fiscal Year 2021 Budget Submission. Vol. II: Medical Programs and Information Technology Programs. P. 81–92.

⁶<http://www.independentbudget.org/>

⁷GAO. "VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement." GAO-09-145. Publicly released: Jan. 23, 2009.

⁸Title I, Subtitle A, Sect. 101, Veterans Millennium Health and Benefits Act (Public Law 106-117).

VA CLCs cost \$1,184 per day compared to \$328 per day in CNH and \$160 per day in SVH.⁹ While the least cost to VA for institutional care is SVHs, 80 percent of veterans receive VA's partial daily rate that covers only about a quarter of their care costs. For the remaining 20 percent of veterans who have a service-connected disability residing in SVHs, VA pays the full cost of their care. VA also pays the full cost of care for CNH but 30 percent of these veterans receive lower cost long-term care and about 70 percent receive the short-term care that many veterans receive in CLC. Considering the cost and quality of the SVH and the unique role they play in long-term care, Congress should consider funding additional construction grants that propose to build out the capacity of these programs.

As younger veterans with acute disabilities and differing needs began to flood the VA in the wake of the Gulf Wars, VA's priorities shifted and long-term care lost out to responding to post-traumatic care needs of a younger population. Creating or revitalizing its programs to respond to these needs shifted resources from LTSS programs. Instituting new community-care programs has lately also consumed VA's resources and focus. VA had begun important end of life care initiatives and important innovations of its non-institutional long-term care portfolio that now continue to languish. This shift in priorities and other reforms have kept VA from revisiting development of a robust strategic plan for meeting veterans' long-term care needs.¹⁰

VA's CLCs continue to offer high quality care, but they are not without their challenges—GAO reported that about 80 percent had vacancies for nurse assistants and home health aides. These shortages are rampant throughout the long-term care industry and often impair program capacity, including for non-institutional options. Innovative solutions for training additional nurse assistants and home health aides are in short supply. VA should aim to be part of the solution to this national problem. Whether this involves reevaluating pay grades, development of tuition support or reimbursement for education, in-house training programs or creation of other incentives, VA can help address this need for these scarce professionals. In addition, it can look at means of incentivizing the reallocation of staff and other resources in more rural locations and offering special training for the specialized care many aging veterans require such as dementia care, behavioral supported care or ventilator dependent care.

Local VA Geriatrics and Extended Care (GEC) programs often prioritize staffing institutional settings rather than home-and community-care programs through the same budget. GAO reports that in 2017, VA spent 63 percent of its obligations for LTSS on institutional care and 37 percent on non-institutional care. By 2037, VA projects spending about 53 percent of its funding on institutional care and 47 percent on home and community programs.¹¹ Whether that split is the "right" balance is unclear. DAV supports GAO's recommendation that VA build a timeframe for a standardized means of determining veterans' needs for non-institutional care options at each VA medical center.

VA has created some specialized care for aging veterans it serves such as those with spinal cord injury and disease. VA, like other health care systems, is having difficulty meeting the needs of veterans with dementia and behavioral issues and those who require ventilators.¹²

Most veterans with family or friends who can play some role in assisting them are eager to return home. Congress made this goal more attainable by enabling family caregivers of veterans of eras on or after September 11, 2001 to assist veterans with service-connected disabilities under the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163). The VA MISSION Act of 2018 (P.L. 115-182) expanded the VA's Family Caregiver Assistance Program to caregivers of service-disabled veterans from eras before September 11, 2001.

DAV developed the Unsung Heroes Initiative to advocate for the expansion of VA's Family Caregiver program to not just veterans with service-connected disabilities who were injured on or after September 11, 2001, but those of later eras aging with disabilities and those who have service-connected illnesses such as ALS, Parkinson's disease or cancers. There is precedence in DoD's Special Compensation for Assistance with Activities of Daily Living program, which covers both injury and disease. Both severe injury and disease can create significant needs for personal assistance and tasks of independent living.

DAV's 2017 report, America's Unsung Heroes, includes a survey of over 1,800 respondents, of whom more than 1,000 were family caregivers, which found that about

⁹Department of Veterans Affairs. Fiscal Year 2021 Budget Submission. Vol. II: Medical Programs and Information Technology Programs. P. 81-92.

¹⁰GAO 20-284, VA Long Term Care, p. 21.

¹¹GAO 20-284, VA Long Term Care, p. 18.

¹²GAO 20-284, VA Long Term Care, p. 21.

three-quarters believe that their loved one would require institutional care without their assistance—now (about 25 percent) or in the future (50 percent).¹³ As they age, caregivers worry that without additional support they will be unable to continue in their caregiving role. Most found that caregiving has taken a toll on their financial stability, friendships, family life, physical health or fitness, mental health and job or career.¹⁴ These family members stated stipends, health insurance, medical training and other supports would be important or very important to them.¹⁵ Other surveys including the 2015 RAND study and the 2010 National Alliance of Caregiving (NAC) study have similar findings about caregiver burdens.^{16 17}

VA's Comprehensive Caregiver Support Program (CCSP) has gone a long way toward addressing the problems of caregivers of post-9/11 veterans. While the legislation has been passed to include caregivers of disabled veterans pre-9/11,¹⁸ the implementation of this legislation has been stalled by technological barriers. The clock is ticking for many of the family caregivers who would be affected by this law—as they age, and the years of caregiving they have already provided continue to take a toll, they may no longer be able to provide the same levels of assistance. Congress required VA to improve its information technology administrative support systems before moving forward with this expansion and significant delays are now impeding thousands of veterans and their families from receiving this support. DAV hopes that this Committee will continue to closely monitor this initiative to ensure the thousands of veterans it would serve can remain in their homes or return there—often at far less cost to the Federal Government.

VA was able to compare a small number of caregivers enrolled and not enrolled in CCSP and found that caregivers in this program felt more confident in their caregiving, were more aware of resources to help in their caregiving role and felt more confident in supporting their veteran. Although things are not perfect in this program, as we have already stated, DAV would support the addition of caregivers whose loved ones have grave illnesses, such as those Vietnam veterans suffering from diseases caused by Agent Orange, veterans suffering from Gulf War Illnesses, and the newest generation of veterans exposed to burn pits and other toxic and environmental hazards. Therefore, DAV endorses Congressman Ruiz's bill, H.R. 4451, the Support Our Services for Veterans Caregivers Act, which would make them eligible for the program. Equally important, the bill would also require VA to conduct a multidimensional assessment to assess the burden and strain caregivers experience while participating in the CSSP.

We also support H.R. 5701, the Care for the Caregiver Act, introduced by Representatives Hudson and Rice. We eagerly anticipate the introduction in the House of a companion bill to S. 2216, The Transparency and Effective Accountability Measures (TEAM) for Veteran Caregivers Act, which we endorse. Collectively, these bipartisan bills would: Require VA to recognize Primary family caregivers as “part of the clinical team” so they can more effectively advocate for their veteran; standardize clinical evaluation for eligibility; extend stipend payments to help the family caregiver transition when the veteran is discharged from the program (due to death or functional improvement); require a minimum standard of information to be included in decision letters so veterans and caregivers understand the basis of such decisions; and establish permanent eligibility criteria for the most catastrophically injured veteran so they do not have to worry about arbitrarily losing caregiver support and services. We urge Congress pass these bills—veterans and their family caregivers have waited far too long for VA to act on these common sense provisions.

Because of our hard work to improve and expand the CSSP, we are concerned about the long-term viability of this important benefit, which is not considered part of the VA's basic care package or among its LTSS programs. Demand for the program from post-September 11 veterans was higher than VA anticipated and taking funds from within appropriations requires a significant shift away from other programming—including its “mandatory” benefits package, which includes long-term care. VA must determine how to meet the growing demand for this program among other LTSS services.

In terms of funding, the Administration's Fiscal Year 2021 request included approximately \$1.2 billion for VA's comprehensive caregiver support program. Because

¹³DAV. America's Unsung Heroes: Challenges and inequities facing veteran caregivers. 2017, p. 10

¹⁴DAV. America's Unsung Heroes: Challenges and inequities facing veteran caregivers. 2017, p. 9

¹⁵DAV. America's Unsung Heroes: Challenges and inequities facing veteran caregivers. 2017, p. 17

¹⁶RAND Military Caregivers Study. 2014

¹⁷National Alliance of Caregiving and United Health Foundation Study. 2010

¹⁸VA MISSION Act of 2018 (P.L. 115–182)

this request represents an overall increase of \$485 million over Fiscal Year 2020, it is noteworthy that \$650 million is to implement the eligibility expansion required under the VA MISSION Act; thus, we are concerned this request assumes a reduction in the number of existing program participants—approximately 20,000 approved family caregivers. The IB recommends appropriating \$779 million for Fiscal Year 2021 for the phase-one expansion scheduled toward the end of Fiscal Year 2020, with only a small portion of the expansion cost absorbed in Fiscal Year 2020. The IB's recommendation is based on the Congressional Budget Office's estimate for preparing the program, including increased staffing and IT needs, and the beginning of the first phase of expansion. To continue the expansion, the IB recommends \$1.4 billion for Fiscal Year 2022.

VA has recently rebranded its non-institutional care program under its "Choose Home Initiative" to expand in-home care options. All veterans who are determined to have a clinical need for it, are eligible for home and community services including home-based primary care, day care, homemaker/health aide services, hospice or respite services. Unfortunately, GAO's recent report notes that there are waiting lists for VA's Home-Based Primary Care program. Over the time studied, about 1,800 veterans were waiting for this care and without intervention given the growing demand for this program, the list will grow.¹⁹

Veteran-Directed Care. If VA determines veterans are in clinical need for such services, veterans or their caregivers may choose Veteran-Directed Care (formerly, VD-HCBS). The Veteran-Directed Care program is administered through a partnership with Health and Human Services Administration for Community Living (ACL) and has proven to be a program that can meet the needs of some of VA's most vulnerable populations, including many who would likely be placed in nursing homes without this option.

Through Veteran-Directed Care, the veteran has the opportunity to manage a monthly budget based on functional and clinical need, hire family members or friends to provide personal caregiver services in the home, and purchase goods and services that will allow him or her to remain in the home. Veterans can also decide to receive assistance from an Options Counselor to help plan care and services, and the veteran can receive financial management support from a Financial Management Services (FMS) organization. To fully administer this program, Veteran Care Agreements²⁰ are used between the local VAMC and its surrounding Aging and Disability Network Agencies (ADNAs) including State Units on Aging (SUA), Aging & Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs) and Centers for Independent Living (CIL).

A recent analysis of Veteran-Directed Care participants' health care use in Fiscal Year 2015 before and after enrolling in this program found 29 percent reduction in inpatient days of care, 11 percent reduction in emergency room visits and 14 percent reduction in other than home-and community-based services. While not conclusive, it suggests clear potential of reducing health care costs while honoring the veteran's choice to remain in their home rather than in an institutional setting. Another example is the program administered at the San Diego VA health care System has partnered with the local AAA to provide veterans in San Diego county access to this program. Cost savings/avoidance for this specific program of \$1.6 million over two years can be found here: https://nwd.acl.gov/pdf/SD%20Visa%20Flyer_100215_508.pdf. Simply, Veteran-Directed Care is capable of serving three veterans for every one residing in a community nursing home at VA's expense.

About 3 years ago, during his confirmation hearing, Secretary nominee David Shulkin committed to expand access to the Veteran-Directed Care program and make it available at every VA medical center within the next 3 years. Unfortunately, VA has made significantly slower progress in adding the sites that make this program available to veterans, adding four new programs in 2019. As of this writing, the Veteran-Directed Care program has 145 providers supporting 69 VAMCs across 37 states, including D.C. and Puerto Rico.

This program is an important mechanism for expanding access to veterans in rural communities and to service-connected veterans with illnesses whose caregivers do not qualify for VA's family caregiver program. However, because this is a discretionary program, much like all the other home-and community-based services, VA offers as part of the veteran medical benefit package, it is up to each VAMC to establish this program and to ensure full coverage across its market area.

Since 1951, the VA's Community Residential Care (CRC) Program has provided health care and sheltered supervision to eligible veterans not in need of acute hos-

¹⁹ GAO 20-284, VA Long Term Care, p. 22.

²⁰ Section 102 of the VA MISSION Act of 2018, Public Law 115-182

pital care, but who, because of medical and/or psychosocial health conditions, are not able to live independently and have no suitable family or significant others to aid them.

The CRC Program is an important component in VA's continuum of long-term care services operating under the authority of title 38, United States Code, Section 1730. Any veteran who lives in an approved CRC residence in the community is under the oversight of the CRC Program. This program has evolved through the years to encompass, Assisted Living such as VA's Medical Foster Home, Personal Care Home, Family Care Home, and Psychiatric CRC Home.

Assisted living bridges the gap between home care and nursing homes. Assisted living is a general term that refers to a wide variety of residential settings that provide 24-hour room and board and supportive services to residents requiring minimal need for assistance to those who require some ongoing assistance with personal care and activities of daily living. VA's MFH program is commonly known as adult foster care homes in the private sector and some residences that are licensed as adult foster care homes may call themselves "assisted living." An adult foster care is a residential setting that provides 24-hour room and board, personal care, protection and supervision for adults, including the elderly who require supervision on an ongoing basis but do not require continuous nursing care.

Medical Foster Home. New partnerships between Home-Based Primary Care (HBPC) and the MFHs and CRCs have allowed veterans to live independently in the community, as a preferred means to receive family style living with room, board, and personal care.

VA must expand the MFH program as an alternative to nursing care for some veterans at a much lower cost (about half the cost of other VA nursing care venues). MFHs serve no more than three individuals with needs for 24-hour care or supervision in private homes. VA makes referrals to such care providers, but is currently not authorized to cover the full cost of this care for veterans. VA has once again asked Congress to authorize it to pay for approved medical foster homes for service-connected veterans in its Fiscal Year 2021 budget submission.

While HVAC is to be commended for passing this legislation out of Committee in previous Congresses, it has not passed H.R. 1527, the Long-Term Care Veterans Choice Act in this Congress. DAV is hopeful that this hearing, along with VA's budget request, will provide the impetus for the Committee to reconsider taking action.

Veterans enrolled in VA who are 70 years and older are projected to increase by 30 percent to about 3.9 million. And 15 years from now, the veterans of the Afghanistan and Iraq wars will be middle aged and many are likely to continue to require support for the same complex co-morbid conditions of post-traumatic stress, traumatic brain injury, chronic pain and orthopedic traumas they struggle with today. Already, VA's long-term care patient profile includes almost 30 percent of veterans who are younger than 65 years old.

Clearly, VA's MFH program should be realigned under a more appropriate statutory authority. Public Law 106-117 authorized an Assisted Living Pilot Program (ALPP) carried out in VA's VISN 20. Conducted from January 29, 2003, through June 23, 2004, and involving 634 veterans who were placed in assisted living facilities, the pilot project yielded an overall assessment report submitted to Congress stating, "the ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."²¹ Unfortunately, VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority at that time to provide assisted living services, because VA considered assisted living to be primarily a housing function.

Despite VA's reticence, the 2004 ALPP report seemed most favorable, and assisted living appears to be an unqualified success. In fact, Title XVII, Section 1705, of the National Defense Authorization Act for Fiscal Year 2008, Public Law 110-181, authorizes VA to provide assisted living services.

Assisted Living for Veterans with Traumatic Brain Injury. Veterans with severe traumatic Brain Injury (TBI) suffer from short-term and long-term changes, including difficulty with attention and concentration, memory, organizational skills, perception, expressing feelings, inappropriate behaviors, and physical impairments.

The Assisted Living for Veterans with Traumatic Brain Injury (AL-TBI) pilot program ran from 2009 through 2017. It provided specialized residential care and rehabilitation to eligible veterans with TBI to enhance their rehabilitation, quality of

²¹Susan H, Marylou G, et al., Evaluation of Assisted Living Pilot Program. Report to Congress. Washington, DC, Office of Geriatrics and Extended Care, VHA, July 2004.

life, and community integration. Veterans meeting eligibility criteria are placed in private sector TBI residential care facilities specializing in neuro-rehabilitation or neurobehavioral rehabilitation.

The pilot has not been extended and without an assisted living program, families and caregivers do not have a fully supported comprehensive plan for long-term services and supports for veterans with severe TBI.

Demands for all types of long-term care will continue to grow into the foreseeable future. DAV agrees with GAO that VA must create measurable goals for its LTSS programs to ensure it is making optimal choices allocating resources to veterans. It must look to less expensive means to provide meaningful care and support. Congress must authorize VA to reimburse care in medical foster homes. VA should more quickly move toward providing more access to home-and community-based services through every VA medical center. It should allocate additional resources in home telehealth and home-based primary care to allow more veterans to recover and be monitored for chronic conditions at home. It should more quickly bring adult day care, respite and hospice programs online. Most importantly, VA must enable as many family caregivers to assist as possible. These options will not only improve the quality of care for our veterans, they are likely to be more satisfactory to veterans and their families and cost less.

Madam Chair, DAV is pleased to have had the opportunity to revisit the topic of VA's Long-Term Service and Supports system for veterans. We look forward to working with this Subcommittee to ensure veteran continue to have access to a full array of LTSS.

Prepared Statement of Mark Bowman

Chairwoman Brownley, Ranking Member Dr. Dunn and Members of the Subcommittee:

Thank you for inviting the National Association of State Veterans Homes (NASVH) to testify on the future of the State Veterans Home program and veterans long term care in general. I currently serve as President of NASVH, an all-volunteer organization dedicated to promoting and enhancing the quality of care and life of veterans and families in State Veterans Homes through education, networking, and advocacy. However, my full time job is Executive Director of the Office of Kentucky Veteran Centers, which oversees the operation of four State Veterans Homes among other responsibilities. I am pleased to join you today on behalf of NASVH to discuss the State Veterans Home program, the current challenges we face and future opportunities to better meet the long term care needs of America's aging and ill veterans and their families.

The State Veterans Home program dates back to the post-Civil War period, when there were a large number of indigent and disabled veterans unable to earn their own livelihood who needed care. While the Federal Government already operated national homes for disabled union volunteer soldiers, the total number of veterans needing care was overwhelming. In recognition of this need, and the debt that a grateful nation owed its defenders, a number of states independently established State Veterans Homes to help care for those who had borne the battle.

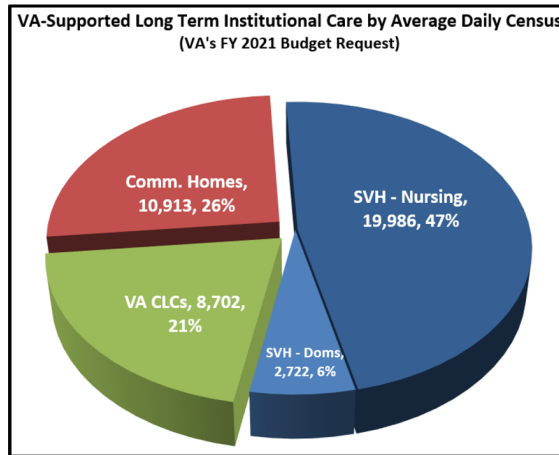
The first State Veterans Home was established in 1864 at Rocky Hill, Connecticut. In 1888, Congress enacted legislation to provide Federal aid (\$100/year) to help alleviate the burden placed upon states. With the establishment of the Veterans Administration in 1930 to care for an ever-increasing number of veterans, the State Veterans Home program was expanded to include additional levels of care as well as a Federal grant program to support the construction of State Veterans Homes.

Madame Chairwoman, as the title of the hearing implies, and the Government Accountability Office (GAO) confirms, the number of aging Vietnam Veterans seeking long term care options from VA will continue increasing over the next decade. In order to address the 'coming tsunami,' VA is going to need all its resources and creativity to provide veterans the long term services and supports they desire and have earned.

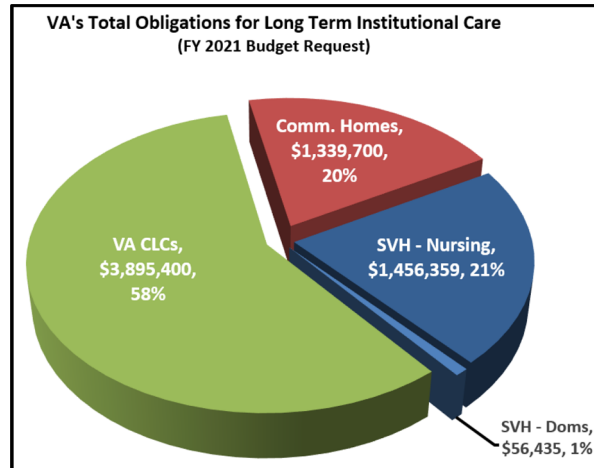
The State Veterans Home program offers two distinct advantages as Congress and VA seek innovative solutions. First, by partnering with states, VA can leverage its long term care dollars to serve more veterans through the State Veterans Home program than by directly providing the services or paying for private sector care. Second, the structure of the State Veterans Home program allows each State to tailor long term care solutions to the unique characteristics and preferences of its veterans. As I have heard many NASVH members say: "If you have seen one State Veterans Home you have seen one State Veterans Home." States can serve as the

laboratories of innovation, and then allow VA and other states to take advantage of their best practices, which NASVH strongly encourages.

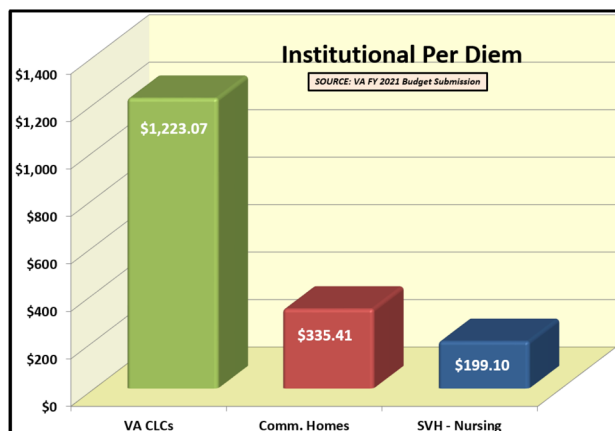
Today, there are 157 State Veteran Homes located in all 50 states and the Commonwealth of Puerto Rico, with over 30,000 authorized beds available, making the State Veterans Home program the largest provider of long term care for our Nation's veterans. As the recent GAO report confirms, "State Veterans Homes had the highest average daily census and provided over half of all institutional care based on the average number of veterans for which VA funded nursing home care on any given day during the year."



However, as VA's Fiscal Year 2021 budget submission makes clear, State Veterans Homes will account for less than one quarter of VA's Fiscal Year 2020 total obligations for long term institutional care.



Furthermore, VA's calculation of the institutional per diem for State Veterans Homes for veterans' nursing home care is 40 percent lower than for private sector community nursing homes and less than one-sixth the cost of VA's own community living centers (CLCs).



As both GAO and VA's budget make clear, investing in State Veterans Homes is the most cost-effective way to maximize VA's Federal dollars to provide convenient, high-quality institutional care for those sick and elderly veterans who have no home-based care options.

Skilled Nursing Care Program

The primary program offered by most State Veterans Homes is skilled nursing care, which provides nursing home care for aging and ill veterans; in some states, widows, spouses, and Gold Star Parents may also be eligible for admission. To support this program, VA provides a per diem payment for each eligible veteran, as well as grants for the construction, expansion, renovation and repair of the Homes.

The basic VA per diem rate for nursing home care is currently \$112.36, which covers approximately 30 percent of the total cost of care, although VA is authorized to provide up to 50 percent. State Veterans Homes make up the balance differently in each State, using a variety of other funding sources, including State support, Medicare and the veterans themselves who share in the cost. As a result of Public Law 112-154, VA also pays a higher prevailing rate for veterans who needs nursing home care due to a service connected disability or for veterans with service-connected disabilities rated at 70 percent or higher. This prevailing rate per diem varies among the states and is considered payment in full by VA.

Insufficient Construction Grant Funding

VA also provides Grants for State Extended Care Facilities, commonly known as State Home Construction Grants, which provide states with up to 65 percent of the cost to build, renovate and maintain Homes, with states required to provide at least 35 percent in matching funds. As a condition of receiving these grants, states must continue to operate the program for at least 20 years or be subject to recapture provisions in Federal law.

State Home Construction Grant requests are categorized into 8 groups, as well as additional subgroups, reflecting statutory priorities. The highest priorities are accorded to life-safety projects as well as the construction of new Homes in states with an insufficient number of beds according to Federal statute. Once a grant request secures its matching State funding it is placed into Priority Group 1 in the order of sub-priority groups and by the date the grant request moved onto the Priority Group 1 List.

Although VA has not yet released the Fiscal Year 2020 Priority Group List, as a result of more States providing new matching funding over the past year, the new Priority Group 1 List is expected to grow to almost \$500 million or more. With an estimated \$700 million worth of grant requests in Priority Groups 2 to 8 awaiting State matching funds, the total Federal share to fulfill all of the pending construction grant requests is estimated to be approximately \$1.2 billion.

Unfortunately, for Fiscal Year 2020, the Construction Grant Program was only appropriated \$90 million, which would allow VA to fund just the first 14 projects on the Priority Group 1 List, leaving a growing backlog for future years. And with further State matching funding expected to move even more grant requests into Priority Group 1 next year, it is imperative that Congress provide sufficient funding

to address the growing backlog. NASVH recommends that Congress appropriate \$250 million for the State Home Construction Grant Program to fund at least half of the pending Priority Group 1 grant requests. We urge this Subcommittee and the full Committee on Veterans' Affairs to include this recommendation in its Views and Estimates to be provided to the Budget Committee this year.

Duplicative External Inspection Surveys

As a condition of receiving Federal funding, VA certifies and closely monitors the care and treatment of veterans in State Veterans Homes. As required by law, VA performs a comprehensive inspection survey of each State Veterans Home annually to assure resident safety, high-quality clinical care and sound financial operations. This inspection survey is typically a week-long top-to-bottom review of the Home's facilities, services, clinical care, safety protocols and financial operations. VA also performs inspection surveys of states include Domiciliary Care and Adult Day Health Care programs. If deficiencies are found at a State Veterans Home, it is required to rectify the deficiency as a condition of keeping its certification.

In addition, about 60 percent of State Veterans Homes are also certified to receive Medicare support for their residents. Just like VA, the Department of Health and Human Services, through the Centers for Medicare and Medicaid (CMS), requires an annual inspection survey for the same purposes of assuring safety and quality care. In fact, the CMS survey is more than 90 percent identical to the clinical life and safety sections of the VA inspection survey. It too is typically a week-long inspection that is not announced in advance. Because these two Federal agencies do not coordinate their inspections, many State Homes have had these two virtually identical inspections occur over consecutive weeks; some have even occurred simultaneously, seriously disrupting the State Veteran Home and its veteran residents. In our view, requiring State Homes to undergo two separate and duplicative Federal inspections surveys – when the Federal standard is one annual survey – is not only disruptive to State Homes, but also financially inefficient for the Federal Government and taxpayers.

To address this problem, NASVH worked with Congressman Tom Suozzi (NY) who introduced legislation in the House to require CMS to use the results of the VA survey to satisfy their annual inspection survey requirements, similar to how CMS uses and accepts the results of certifications by the Joint Commission for hospital accreditation. H.R. 4138, the State Veterans Home Inspection Simplification Act, has growing bipartisan support in the House; companion bipartisan legislation, S. 3350, was recently introduced in the Senate by Senators Mike Crapo (ID) and Jon Tester (MT). These bills would not prevent CMS from investigating any complaints in State Veterans Homes, but would simply prevent unnecessary duplication of annual Federal inspections. Furthermore, the legislation contemplates CMS working out an agreement with VA to add any inspection items or questions to the VA inspection survey that CMS determines necessary. NASVH strongly supports passage of the State Veterans Home Inspection Simplification Act and asks for the support of all members of the Subcommittee.

It is important to understand that in addition to the VA and CMS inspections, State Veterans Homes are also subject to both regular and periodic inspections and audits from State agencies, the Inspector General of the Department of Veterans Affairs, and the Civil Rights Division of the Department of Justice, among other inspectors. Moreover, they are held accountable to the general public through oversight by Congress, veterans service organizations and the media.

Each State is also accountable for ensuring veterans in its State Veterans Homes receive quality long term and other health care services, and are focused on achieving high patient satisfaction in comfortable and safe conditions. State Veterans Homes generally function within a state's department or division of veterans' affairs, public health, or other accountable agency, and typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public bodies. Finally, State Veterans Homes hold themselves accountable for the quality of care through myriad internal management controls, State and Federal long term care regulations, and integration of model policies, practices and standards advocated by the NASVH and other standards bodies, for the continuous quality improvement of their programs of care for sick, elderly and disabled veterans.

Mental Health and Behavioral Issues

The VA nursing home per diem provided to State Veterans Homes covers, among other items, basic primary care for veteran residents; specialty care is not considered part of the per diem. However, VA has been treating all mental health care as an obligation of the Homes, despite the fact that mental health care is a form

of specialty care. Psychiatrists and psychologists are medical specialties, not part of basic primary care. Yet, VA has taken the position that State Veterans Homes must bear the full cost of providing mental health care to their resident veterans. Given the high costs for psychiatrists and psychologists, many State Veterans Homes may not be able to continue admitting veterans with significant mental health issues, leaving these veterans with fewer options at a time when veteran suicide is a national crisis and top VA and congressional priority. NASVH believes VA should be responsible for providing eligible veterans with their mental health care, in the same manner as VA provides enrolled veterans all other necessary specialty care, and asks for support from the Subcommittee for this position.

In fact, a number of State Veterans Homes have indicated that they would be willing and capable of providing care for veterans with severe behavioral issues or serious mental illness if a higher per diem or other cost subsidization were made available, since such veterans require intensive supervision, often one-to-one, as well as more direct care that is significantly more costly. NASVH is interested in exploring potential programs or similar models of care that State Veterans Homes might be able to offer for this very challenging veterans population.

Domiciliary Care Program

State Home Domiciliary Care programs provide alternative long term support for veterans who are not in need of skilled nursing care, but who need shelter and supportive services. There are approximately 6,000 Domiciliary Care beds in 50 State Veterans Homes in 30 states, including California, Florida, Illinois, Michigan, Pennsylvania, Ohio, Illinois and Virginia. The State Home Domiciliary Care program can play an integral role in VA's mission of helping the homeless and providing a safety net for veterans in their communities. The level of care in Domiciliaries varies from State to State, with some providing only basic food and shelter, and others offering more enhanced levels of support that may include social, vocational and employment services.

Based on a recent NASVH survey, the average age of Domiciliary residents is about 75 and the average length of stay is 3.5 years. The average daily total cost per Domiciliary resident was reported by State Homes as \$187; however that cost will rise as the financial burden of the new regulations takes full effect. VA provides a Domiciliary per diem of \$48.50, which is roughly 25 percent of the total daily cost reported by State Homes.

In November 2018, a decade after first initiating a rulemaking process for State Veterans Homes Domiciliary and Adult Day Health Care programs, VA finally promulgated new regulations (RIN-2900-AO88) governing these programs; full enforcement of the new regulations began in May 2019. Unfortunately, the decade-long delay in finalizing the Domiciliary regulation resulted in a number of unintended problems for States who currently operate such programs. The most significant change is unexpected increases to the minimum staffing requirements and other care changes that have significantly increased the costs to State Veterans Homes, without increasing the VA per diem. As a result, many states are considering closing the programs, leaving hundreds, perhaps thousands, of veterans at greater risk of becoming homeless. NASVH calls on Congress to work with VA to provide relief to these Domiciliary Care programs either by increasing the VA per diem rate to a more realistic amount or by making significant corrections to the regulations in consultation with State Veterans Homes.

Another negative impact of the new regulations has been VA's inconsistent enforcement of eligibility requirements. Previously, VA had not strictly enforced Domiciliary eligibility requirements, allowing veterans who had some challenges in performing all the activities of daily living (ADLs) to qualify for a Domiciliary per diem, if the State Veteran Home was providing adequate support using non-VA resources. However, since promulgation of the new regulations, local VA facilities who oversee the Homes began precluding a number of current Domiciliary residents from being eligible for VA per diem because they were unable to perform all ADLs independently, without even minor assistance. VA also began enforcing a work requirement for Domiciliary residents, even though such requirements are not allowed in many states. In addition, some State Homes – with the full knowledge and support of VA – have been operating higher levels of Domiciliary Care programs for veterans, such as for dementia care or assisted living, and could be forced to shut down if the new enforcement continues. It is important to make clear that the Domiciliary programs referenced above are providing a higher level of care than what the Domiciliary per diem covers, all at the state's expense.

Recognizing the problems created by the recent Domiciliary regulation, VA encouraged State Veterans Homes who had current residents excluded from the Domiciliary per diem program to apply for equitable relief. This past December Secretary

Wilkie granted equitable relief for 190 current Domiciliary residents, allowing them to continue receiving the VA per diem support. However, a renewed request for these veterans will have to be made annually and – most importantly – these Domiciliary programs will not be able to admit similarly situated veterans in the future, further threatening the sustainability of Domiciliary Care programs.

To address the known problems with the recent Domiciliary regulations, VA has indicated it intends to initiate a new rulemaking process, however NASVH is concerned that this could take years to be finalized, just as it took over a decade for the current regulation. Furthermore, there is no certainty that the new regulations will actually fix the current problems or strengthen the program. NASVH calls on Congress to work with VA to address the known problems and explore possible legislative remedies. For example, Congress could authorize enhanced levels of Domiciliary care, such as care for dementia, which would better address the current and future needs of veterans who need less than Skilled Nursing Care. Such a program could start initially as a pilot program to test different models of enhanced domiciliary care.

Adult Day Health Care (ADHC) Program

Adult Day Health Care is a non-institutional alternative to a skilled nursing facility for aging veterans who have sufficient family support to remain in their own homes, but who need or will benefit from a day program at a State Veterans Home to promote wellness, health maintenance, and socialization. In addition, ADHC can help to maximize the participant's independence and enhance their quality of life, as well as provide much-needed respite for family caregivers. A higher level of ADHC, known as medical supervision model Adult Day Health Care, also provides comprehensive medical, nursing and personal care services combined with social activities for physically or cognitively impaired adults. The medical supervision model ADHC program is staffed by caring and compassionate teams of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs. A medical supervision model ADHC program can help veterans remain in their own homes for additional months or years, thereby improving their quality of life. It can also lower the cost and burden on VA by deferring or delaying their use of more expensive skilled nursing care and can help frail, elderly veterans avoid unnecessary emergency room admissions and hospitalizations as well.

Over the past several years there have only been three State Veterans Homes operating ADHC programs – New York, Minnesota and Hawaii – in large part due to an inadequate per diem rate for most states to make it financially viable. Fortunately, in March 2018, Congress passed and the President signed the State Veterans Home Adult Day Health Care Improvement Act (P.L. 115–159) which established a higher per diem for medical supervision model ADHC for veterans who have a service-connected disability rated at 70 percent or more, or who needs medical supervision model ADHC care for a service-connected disability. The law requires VA to enter into agreements with State Veterans Homes to, "...adequately reimburse the State home for the care provided by the State home, including necessary transportation expenses." In fulfillment of this requirement, VA has recently consulted with several members of NASVH who operate or are considering operating medical supervision model ADHC programs. We are hopeful that VA will offer a path forward that allows other states who have shown interest to open their own programs in the coming years. We encourage the Subcommittee to remain engaged with VA as it finalizes these new ADHC per diem rates so that more veterans – and their family caregivers – can benefit from the higher level of assistance offered by medical supervision model ADHC.

To further encourage State Veterans Homes to operate ADHC programs, VA and Congress should modify the Construction Grant program so that funding can be used to support the construction of new, or modification or expansion of existing facilities for ADHC programs. Given the small size of some of these programs, the Construction Grant program should also support State Homes seeking to establish satellite ADHC programs within existing medical space that is more conveniently located in areas with higher concentrations of veterans.

Future Opportunities for State Veterans Homes

Madame Chairwoman, State Veterans Homes are a trusted and valuable partner for VA to help meet the evolving needs of aging and ill veterans, through both existing and potentially new institutional and non-institutional programs. State Veterans Homes already have an existing infrastructure as well as knowledge and experience operating safe, high-quality long term care programs. Give the flexibility and financial benefits to VA from partnering with State Veterans Homes, there are myriad

possibilities for better addressing the changing demographics, needs and preferences of veterans today and in the future. As previously discussed above, many State Veterans Homes would have interest in providing additional levels of care that are higher than allowed under Domiciliary Care, but lower than required for Skilled Nursing Care. Such “enhanced” Domiciliary Care could help to fill gaps between these two programs and better meet the needs of veterans and their families.

State Veterans Homes could also be used to expand non-institutional care by encouraging greater usage of Adult Day Health Care, as well as additional home-based programs. For example, a State Veteran Home that provides medical supervision model ADHC might also be able to operate a Home Based Primary Care program that would be able to fulfill all of the needs of a veteran to allow him or her to remain in their home. Such an integrated non-institutional program could begin as a pilot program, with different states customize its pilots to meet local circumstances. NASVH recommends that the Subcommittee consider establishing such pilot programs to explore new arrangements for providing integrated non-institutional care programs through and in partnership with State Veterans Homes.

Creating a True Partnership with VA

Finally, in order to fully maximize State Veterans Homes’ resources and capabilities, VA must commit itself to a true partnership. Too often, State Veterans Homes are an afterthought in VA’s planning and budgeting processes. For example, the GAO report presented today relies on incomplete VA data projections for State Veterans Homes. The report notes that in looking at VA’s future long term care utilization, “VA projection data... do not include projections for State Veterans Homes or State Adult Day Health Care programs...” because State Veterans Homes are not incorporated into VA’s Enrolled Health Care Projection Model. By contrast, private sector community nursing homes are included in VA’s projections.

Another example is the lack of representation by State Veterans Homes on VA’s Geriatrics and Gerontology Advisory Committee (GGAC), despite NAVSH nominating three highly qualified State Veteran Home administrators. By contrast, the GAO report notes that the, “...committee members included a member from a nursing home industry group...” despite the fact that the State Veterans Home program being larger and more cost effective. State Veterans Homes need a seat on the GGAC and at the table whenever VA is engaged in long term care planning.

Finally, to be a true partner with VA, the State Veterans Homes need to have a single responsible office inside VA which oversees all aspects of the program. Currently, State Veterans Homes are overseen by at least three major program offices: Geriatrics and Extended Care; Central Business Office; and the Construction Grant Program Office. While VA has designated a lead point of contact, the lack of true programmatic leadership has resulted in a lack of visibility and lack of advocacy within VA for the State Veterans Home program. With a VA budget for State Veterans Homes per diem topping \$1.5 billion, it is time for VA and Congress to consider establishing an Office for State Veterans Homes within VA.

Chairwoman Brownley, while there has been rebalancing inside VA between institutional and non-institutional care in recent years, a trend that is projected to continue in the future, we must remind the Subcommittee that the need for traditional nursing home care is neither diminishing nor will it ever go away. The total average daily census for all VA-supported nursing home, both long stay and short stay, is about 40,000 total; this is just a fraction of a percent of the total number of veterans over the age of 65, a population that is expected rise in the coming decade. NASVH and our member State Veterans Homes will continue to seek new and innovative ways of delivering long term services and supports to aging and ill veterans, however it would be a grave mistake to neglect the existing infrastructure provided by State Veterans Homes. That concludes my statement and I would be happy to respond to any questions you may have.

STATEMENTS FOR THE RECORD

Prepared Statement of Paralyzed Veterans of America

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to provide input as you examine the Department of Veterans Affairs' (VA) readiness to handle rapidly growing numbers of aging veterans who are relying on VA for their health care.

PVA continues to be concerned about the lack of VA long-term care (LTS) services for veterans with spinal cord injury or disorder (SCI/D). Approximately 8,650 of our members are now over 65 years of age and more than 4,000 are currently between 55 and 64. These aging veterans are experiencing an increasing need for VA's home and community-based services and VA's specialized SCI/D nursing home care. Unfortunately, we believe that VA is not requesting, and Congress is not providing, sufficient resources to meet the demand.

In 2012, VA's own research¹ warned that a wave of elderly veterans with SCI was coming and the department should prepare for them. At the time, aging veterans, new cases of SCI from recent conflicts, and increasing numbers of women veterans were dramatically changing the profile of the Veterans Health Administration's (VHA) SCI/D population. Sadly, little preparation has taken place since that time. VA's SCI footprint is relatively the same and the wave is peaking and ready to crest.

Like the general VHA population, veterans with SCI/D are aging in large numbers. Growing older imposes additional physical and medical challenges on all veterans, but especially for those with an SCI/D. Having an SCI/D can exacerbate physical and physiologic declines—including in the musculoskeletal, cardiovascular, gastrointestinal, pulmonary, and integumentary systems—brought on by the aging process. Furthermore, veterans with SCI/D are also more likely than the general population to experience chronic pain, bone loss, pressure injury (pressure sores), kidney and bladder stones. As a general rule, the need for direct, hands on care increases exponentially as veterans with SCI/Ds age.

A small but distinct subpopulation among veterans approaching the silver tsunami, are women veterans with SCI/D. Women are one of the fastest growing groups of veterans. Women veterans with an SCI/D are less likely to be married; have a higher burden of disease, and greater reliance on outside assistance; are diagnosed with more health conditions than men; and have higher diagnosis rates of lifetime depression.

PVA believes that the most pressing concerns for addressing the needs of aging veterans with catastrophic disabilities include preserving access to VA's specialty care services, increased access to VA's caregiver supports, and improved access to VA's long-term services and supports. We will discuss each of these issues below.

Preserve Access to Specialty Care Services

Catastrophically disabled veterans are among the most vulnerable individuals VA serves. It is essential that VA preserves its capacity to provide specialty care services. PVA consistently testifies that VHA is the best health care provider for veterans. The VA's SCI/D System of Care, comprised of 25 SCI Centers and six LTC facilities, provides a coordinated life-long continuum of services for veterans with an SCI/D that has led to increased lifespans of these veterans by decades. VA's specialized systems of care follow higher clinical standards than those required in the private sector. Preserving and strengthening VA's specialized systems of care—such as SCI/D care, blinded rehabilitation, amputee care, polytrauma care, and mental health care—remains the highest priority for PVA. However, if VA continues to woefully understaff facilities, their capacity to treat veterans will be diminished, which

¹“Who are the women and men in Veterans Health Administration's current spinal cord injury population?” <https://www.rehab.research.va.gov/jour/2012/493/pdf/page351.pdf>.

could lead to the closure of facilities, halt improvements in the lives of those with SCI/D, and reduce the services available to them.

Nearly 49,000 VA staffing positions went unfilled last year. In September 2019, VA's Office of the Inspector General² reported that 131 of the 140 VA medical facilities had severe shortages for medical officers and 102 of the 140 facilities had severe nurse shortages. Additional shortages in Human Resources Management positions compounded this problem department-wide. In 2015, SCI/D nurses worked more than 105,000 combined hours of overtime due to understaffing. A system that relies upon floating nurses, not properly trained to handle SCI patients, overworks existing SCI/D nursing staff. This leads to burn out, injury, and loss of work time or staff departure and is unacceptable. In some circumstances, it even jeopardizes the health care of veterans.

VA's ability to meet the highest standard of care to our veterans relies on more than just having the right number of physicians and nurses. They also need qualified and well-trained housekeepers. Last year, at some VA medical facilities, staffing levels for environmental (custodial) employees dipped below 50 percent, which heightens the health risks to veteran patients, particularly those with compromised immune systems, such as those with serious illnesses or catastrophic injuries. Low pay, a cumbersome hiring process, and a lack of qualified applicants are often cited as major contributing factors to the VA staffing problem.

Staffing problems have a direct, adverse impact on the SCI system. Lengthy, cumbersome hiring processes make it difficult to hire and retain staff, which prohibits SCI/D Centers from meeting adequate staffing levels necessary to care for this specialized population. PVA estimates there is a shortage of 600 nurses in the SCI/D System of Care. Considering SCI/D veterans are a vulnerable patient population, the reluctance to meet legally mandated staffing levels is tantamount to willful dereliction of duty. SCI/D Centers with nursing shortages limit bed availability for admission to an SCI/D Center, reducing access for specialized care delivery. Veterans are often admitted to a VA non-SCI/D ward and treated by untrained SCI/D clinicians for days or weeks until an SCI/D bed becomes available. As SCI/D LTC facilities are exceptionally limited, veterans with SCI/D who have chronic medical issues are being treated in community institutions, by providers not trained in SCI/D. This results in compromised quality of care and poor outcomes. Given the magnitude of this situation, PVA strongly advocates for Congress to provide enough funding for VA to reform its hiring practices and hire additional medical professionals, particularly physicians, nurses, psychologists, social workers, and rehabilitation therapists, to meet demand for services in the SCI/D System of Care and ensure the positions, pay, and other incentives they offer are competitive with the private sector.

Increase Access to VA Caregiver Supports

The VA MISSION Act requires VA to expand access to the Comprehensive Family Caregiver program to include veterans who incurred a serious injury on or before May 7, 1975; and two years later, to those who incurred or aggravated a serious injury in the line of duty after May 7, 1975, through September 10, 2001. The law further required the Secretary to implement an information technology system that fully supports the program and allows for data assessment and comprehensive monitoring of the program on or before October 1, 2018. VA has failed, however, to meet any of the deadlines to expand this benefit. Consequently, thousands of eligible veterans and their caregivers will have to wait longer than Congress intended.

VA continues to provide shifting goals for its rollout of the expansion of the caregiver program. Without accountability and follow through, these goals mean nothing and weaken the belief in the VA's ability to fulfill their obligations to those most in need. At the February 27, 2020, House Veterans' Affairs Committee hearing on VA's Fiscal Year 2021 budget, Secretary Wilkie stated VA's current goal for expansion of the caregiver program is June 2020. PVA calls on Congress to perform effective oversight to press VA to implement the expansion of caregiver benefits to eligible veterans and caregivers by June. Also, since Congress intended the final phase of the expansion to service-connected injured veterans be initiated on October 1, 2021, we call on Congress to hold the department to that date so these veterans will not experience further delays.

There is, however, another deserving group of veterans who were not included under the original program or the expansion: veterans with service-connected illnesses such as amyotrophic lateral sclerosis (ALS) or the hundreds of other illnesses

²Veterans Health Administration, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, September 30, 2019, <https://www.va.gov/oig/pubs/VAOIG-19-00346-241.pdf>.

included in the VA's Presumptive Disease List. This too is unjust. For this program to be genuinely inclusive of all our Nation's veterans and their caregivers, it must not exclude those with service-connected illnesses. Therefore, PVA urges the Committee to approve H.R. 4451, the "Support Our Services to Veterans Caregivers Act" by Representatives Ruiz and Higgins which would expand the program to veterans with service-connected catastrophic illnesses, not just injuries, from all eras of service.

Improve Access to VA's Long-Term Services and Supports

PVA continues to be concerned about the lack of VA LTC beds and services for veterans with SCI/D. Many aging veterans with an SCI/D are currently in need of VA LTC services. Unfortunately, VA is not requesting and Congress is not providing sufficient resources to meet the current demand. In turn, as a result of insufficient resources, VA is moving toward purchasing care in the community instead of maintaining in-house LTC for these veterans, even though it is very difficult to find placement for veterans who are ventilator dependent.

VA designated six specialized LTC facilities because of the unique, comprehensive medical needs of veterans with SCI/D, which are usually not appropriately met in community nursing homes and non-SCI/Designated facilities. These veterans require more nursing care than the average patient. Additionally, in SCI/D LTC units, the distribution of severely ill veterans is even more pronounced as a sizable portion require chronic pressure ulcer, ventilator, and bowel and bladder care due to secondary complications of SCI/D issues.

The Long Beach VA Medical Center is the department's newest LTC facility and it is also the only SCI/D LTC Center located west of the Mississippi to serve 11 acute SCI/D Centers. It has a capacity of 12 inpatient beds and because it is always full, it has a long wait list to receive admissions. A recent GAO report³ stated that veterans needing LTC have moved from the Northeast to the South, and that VA now has too many LTC beds in the Northeast and too few in the South. While the GAO report focused on veterans in general, the same finding likely holds true for those with SCI/D. Unfortunately, the woefully inadequate number of beds available barely addresses the high demand. In these instances, the only option is to place the veteran into the local community where they receive suboptimal care by untrained SCI/D-health professionals.

Four of the six SCI/D LTC Centers have sufficient staffing. Of the other two facilities, one has some staffing needs and the other is in dire need of personnel. Thus, some facilities are operating at or near capacity, while others only achieve a fraction of theirs. The VA claims they face challenges hiring staff needed for LTC facilities and this problem will grow as the Nation's health care provider shortage worsens.

Although VA has identified the need to provide additional SCI/D LTC facilities and has included these additional centers in ongoing facility renovations, such plans have been languishing for years.

Currently VA has 18 SCI/D-related construction projects in various states of priority and design. Some are partially funded but need more money assigned against the project in order for it to proceed. The Administration is requesting funding for two major projects in its Fiscal Year 2021 budget proposal to Congress;⁴ a new SCI/D Center with 30 (replacement) acute beds and 20 (new) LTC beds in San Diego, California, as well as a new 30 bed LTC Center with space for an additional future 30 beds in Dallas, Texas. PVA encourages Congress to fulfill their funding request for this pair of desperately needed facilities, but also urges you to increase funding for the Dallas LTC Center to complete all 60 beds at the same time. Last, in accordance with the recommendations of "The Independent Budget Policy Agenda for the 116th Congress," PVA recommends that VA SCI/D leadership design an SCI/D LTC strategic plan that addresses the need for increased LTC beds in VA SCI/D Centers.

VA also offers a number of specialized long-term services and supports to include Spinal Cord Injury-Home Care, Medical Foster Homes, Veterans Directed Care, and Respite Care. All of these programs are covered by VA, with the exception of the Medical Foster Home program. In accordance with VA Policy, VHA Directive 1141.02(1), Medical Foster Home Procedures, VA may refer veterans to a VA approved Medical Foster Home, but VA does not have the authority to cover the cost of services provided.

³GAO-19-478, Estimating Resources Needed to Provide Community Care: <https://www.gao.gov/products/GAO-19-478>

⁴FY 2021 Budget Submission for the Department of Veterans Affairs, Construction and Long-Range Plan, <https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIVconstructionAndLongRangePlan.pdf>.

Medical Foster Homes serve as an alternative to nursing homes for selected veterans who are no longer able to live independently due to functional, cognitive, or psychosocial impairment, at about half of the cost of nursing home care and are intended to serve veterans who are unable to live independently due to functional, cognitive, or psychosocial impairment resulting from conditions such as complex chronic disease, psychological disorder, SCI/D or Polytrauma. Medical Foster Homes are private residences where the caregiver and relief caregivers provide care and supervision 24 hours a day, 7 days a week. Based on a veteran's income and the level of care they need, the monthly charge for a Medical Foster Home is about \$1,500 to \$3,000.

We urge the Committee to approve H.R. 1527, the "Long-Term Care Veterans Choice Act," which would authorize VA to enter into contracts with Medical Foster Homes that meet VA's standards and to cover the cost of care. Medical Foster Homes allow veterans to remain in a more home-like environment and receive adequate care and services at a fraction of the cost of living in a nursing home or LTC facility. It's a win-win for the veteran and the taxpayer.

Chairwoman Brownley, Ranking Member Dunn, PVA appreciates this opportunity to express our views on VA's current readiness to address the needs of aging veterans with catastrophic disabilities. We look forward to working with the Subcommittee on increasing VA's capacity.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

Fiscal Year 2020

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$253,337.

Fiscal Year 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$193,247.

Fiscal Year 2018

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$181,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

Prepared Statement of The Elizabeth Dole Foundation

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, the Elizabeth Dole Foundation is pleased to provide our comments in advance of the Subcommittee's hearing, "*The Silver Tsunami: is VA ready?*" We applaud the Subcommittee for focusing its attention on VA's readiness to meet the needs of the largest cohort of Veterans, baby boomers, as they enter old age.

We thank the Subcommittee for its continued support of the estimated 5.5 million military and Veteran caregivers nationwide, many of whom are caring for an aging Veteran population. According to the 2012 U.S. Census brief, there are over 12.4 million Veterans who are 65 years old or older, mostly consisting of those who served in World War II, Korea, Vietnam, and even the Persian Gulf. Every conflict or military engagement comes with its own unique set of health challenges for active duty service members, and as Veterans age, the long term effects of their injuries or illnesses are only compounded by the natural effects of aging.

A recent GAO report found that more than half a million Veterans received long-term care from the VA in 2018, either in a nursing home or through elder care and home support programs. Demand for long-term care increased 14 percent from 2014 to 2018, alone. Over the next decade, pre-9/11 Veterans will increasingly require long-term care. The VA projects that their spending on long-term care will double by 2037. However, increasingly, aging seniors and baby boomers are seeking to age-

in-place and remain in their homes for as long as possible before seeking institutional care. In fact, a 2016 AARP study found that more than 90 percent of adults over the age of 65 report they would prefer to stay in their current residence as they age. Home-based geriatrics care is an attractive option for patients and the VA alike, potentially representing millions of dollars in savings each year. However, a home-based solution is often dependent on family caregivers, who support everything from medication assistance and wound care to food preparation and mobility assistance.

In 2014, the Elizabeth Dole Foundation commissioned a study by the RAND Corporation to better understand the needs of our Nation's Hidden Heroes, the spouses, parents, siblings, and other loved ones providing care for our Nation's wounded warriors. Beyond quantifying the number of military caregivers as 5.5 million individuals nationwide, the report provided us with insights regarding the demographics of this population and specific challenges these military families were facing. Key findings from this study include:

- Seventeen percent of civilian caregivers reported spending more than 40 hours per week providing care (8 percent reported spending more than 80 hours per week)
- Military caregivers consistently experience worse health outcomes, greater strains in family relationships, and more workplace problems than non-caregivers, and post-9/11 military caregivers fare worst in these areas.

The Elizabeth Dole Foundation commends VA's Geriatrics and Extended Care Program and their new Choose Home Initiative which seeks to establish partnerships to support aging Veterans with home aids and support within their homes. **However, evidence is mounting that more support is needed to help the millions of military and veteran caregivers who will increasingly be called upon for support as Veterans age over the next decade.**

A cornerstone of this additional support is expansion of the VA Program of Comprehensive Assistance for Family Caregivers (PCAFC) that was authorized in the VA MISSION Act of 2018. To date, PCAFC has been restricted to post-9/11 Veteran caregivers, effectively shutting out the estimated 4.4 million veterans caregivers who support pre-9/11 Veterans. With the MISSION Act, VA was authorized to use a phased approach to expand PCAFC to eligible Veterans from all eras. However, despite passage of the MISSION Act in 2018, expansion of the program has been met with frequent delays by the VA, with the Department struggling to get new technology and processes in place to be able to process new applicants to the program. **We ask that the Subcommittee continue to pressure VA officials for updates regarding the PCAFC expansion effort, so that we are supporting the millions of Hidden Heroes nationwide who are providing countless hours of support to our wounded warriors each day.**

Beyond the PCAFC, there are a number of other VA programs that provide support for aging Veterans and their caregivers. These include:

- The VA Fiduciary Program
- Veteran Directed Home & Community-Based Care
- Aid & Attendance Pension Benefit
- Housebound Pension Benefit
- Respite Care

We have provided a short summary on each of these programs below for your reference.

VA Fiduciary Program

The VA Fiduciary Program was established to protect Veterans who, due to an injury, disease or aging issues, are unable to manage their financial affairs. In these instances, VA will appoint a fiduciary to oversee financial management of VA benefit payments. Often time, family caregivers or other family members serve as fiduciaries for beneficiaries, however if family or friends are not able to serve, the VA can also work with qualified individuals or organizations to serve this role.

The Elizabeth Dole Foundation notes that the Fiduciary Program is an important resource for caregivers of aging Veterans. Often, these Veterans are receiving a number of different benefits that must be managed—VA benefits, social security payments, retirement benefits, etc. While becoming a fiduciary comes with a number of important responsibilities, the program allows for the caregiver to be an ac-

tive member of the Veteran's team and ensure that the financial well-being of the veteran is in order.

Veteran Directed Home & Community Based Care

In partnership with the VA, the Department of Health and Human Services established the Veteran Directed Home & Community Based Care program (formerly known as VD-HCBS). Veteran Directed Home care is a consumer directed service that allows for Veterans to choose what kind of care they need and deserve. Since the program's launch, the Elizabeth Dole Foundation has heard from countless Veterans and caregivers participating in the program that the flexibility of the care model has increased their family's quality of life substantially. However, a challenge with the program is that it is only offered in 37 states and individual VA Medical Centers are responsible for establishing a Veteran Directed Home Program at their facility. We ask that the Subcommittee pressure the VA to push for full expansion of the program to all 50 states.

VA Aid & Attendance Benefit

Under this Veteran Benefits Administration benefit, eligible Veterans may receive a VA Aid and Attendance monthly benefit added to their monthly VA pension to help with activities of daily living. A Veteran may use these funds to pay an informal caregiver to provide the care and support they may need. This informal caregiver can be an adult child, grandchild, or other family member; however paying a spouse to provide that in-home care is not viable through this option. Like many of these options, the eligibility for this benefit is a challenge. In order to be eligible, the veteran must first qualify for the basic VA pension.

Housebound Pension Benefit

Similar to the Aid & Attendance pension, the Housebound Pension Benefit allows Veterans who is permanently disabled to pay a non-spousal relative to be their caregiver. In order to qualify for this pension benefit, the veteran must qualify for a basic VA pension and prove that they are unable to leave the home due to disability.

Respite

No matter the benefits that a veteran and their caregiver may qualify for, respite may be the most important benefit that is available to a caregiver. Respite allows for a caregiver to take a short-term break to recharge. While the VA does offer respite, not all caregivers qualify. Respite care is also offered through a myriad of local and State resources through grants from the Department of Health and Human Services and the LIFESPAN Respite Care Act. The challenge of having respite care offered through many different venues and different eligibility requirements, means that caregivers may feel too exhausted to explore their options because it is too much work to navigate the systems on their own. The Elizabeth Dole Foundation has long advocated for accessibility to quality respite care for veteran caregivers. If a caregiver is not able to provide the care their veteran needs due to caregiver burn-out, the family may have to explore the options of institutional care.

Often Veteran caregivers give up their lives to serve their Veterans and ensure that they receive the quality of life they deserve after making the ultimate sacrifice in service to our Nation. As the American health care system prepares for the largest population subset to enter retirement, the Veterans Health Administration and the Veterans Benefits Administration must also prepare to support the Veteran caregivers that will be taking care of these aging veterans. With statistics showing that many pre-9/11 Veteran caregivers are often the children of Veterans, this may mean they are part of the "sandwich generation," providing simultaneous care for their parents and their children. This will bring about its own set of challenges that the DoD, VA, and HHS must be prepared to address.

A challenge that will need to be addressed is the eligibility and criteria for these benefits and programs. The Elizabeth Dole Foundation urges Congress, the VA, DoD, and HHS to listen to the caregivers who are performing these tasks for this population of Veterans to better understand their needs so the systems can be better prepared for the "silver tsunami."

Thank you again for this opportunity to provide a written testimony to the House Veteran's Affairs Subcommittee on Health for the "*Silver Tsunami: is the VA ready?*" hearing. We look forward to our continued work together to support our Nation's military and veteran caregivers.