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**STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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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 towards 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

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

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

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% 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 FY 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 FY 2016, VA spent 71% of its LTSS budget on institutional care and 29% in home- and community-based care and for FY 2021, VA plans to spend 67% of its LTSS budget on institutional care and 33% 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 FY 2019—a 21 percent increase over FY 2016, when 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% of its proposed budget authority for FY 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;

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

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% 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% 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% were 85 or older. LTSS is not just for aging veterans—16.7% 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%) 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% or more (priority 1A)--who enter its community living

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

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

⁶ <http://www.independentbudget.org/>

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

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% of veterans in VA's CLCs are considered "short-stay" and only 20% "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.

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% 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% 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,

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

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

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

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% of its obligations for LTSS on institutional care and 37% on non-institutional care. By 2037, VA projects spending about 53% percent of its funding on institutional care and 47% 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 three-quarters believe that their loved one would require institutional care without their assistance—now (about 25%) or in the future (50%).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

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

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

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

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

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

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

¹⁶ RAND Military Caregivers Study. 2014

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

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

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 FY 2021 request included approximately \$1.2 billion for VA's comprehensive caregiver support program. Because this request represents an overall increase of \$485 million over FY 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 FY 2021 for the phase-one expansion scheduled towards the end of FY 2020, with only a small portion of the expansion cost absorbed in FY 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 FY 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.

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

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 FY 2015 before and after enrolling in this program found 29% reduction in inpatient days of care, 11% reduction in emergency room visits and 14% 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 three 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 three 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 hospital 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.

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

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 FY 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% 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 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 measureable 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

²¹ Susan 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.

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.