NATIONAL PACE ASSOCIATION

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Statement for the Hearing Record
Aging in Place: Examining Access to Home and Community Based Services
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
July 27, 2021

On behalf of our members including 121 Programs of All-Inclusive Care for the Elderly (PACE) organizations in 27 states, and numerous other entities pursuing PACE development and supportive of PACE, the National PACE Association (NPA) appreciates the opportunity to submit a statement for the record to the Subcommittee on Health, Committee on Veterans' Affairs for the hearing titled, "Aging in Place: Examining Veterans' Access to Home and Community Based Services," held July 27, 2021.

PACE organizations (POs) serve among the most vulnerable of our nation—highly medically complex older adults over age 55 who are State certified as requiring a nursing home level of care. The sole objective of PACE is to maintain the independence of older Americans needing a nursing home level of care, by empowering them to remain living safely in their homes and communities for as long as possible. The PACE care model combines excellence in clinical care and care coordination, a dedicated staff of providers and a focus on providing effective, cost-efficient care. The scope of services provided spans all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports medically necessary to maintain or improve the health status of participants 24 hours a day, 365 days a year. As a result, nursing home placements may be delayed or avoided entirely for those in the care of PACE programs.

Using a unique, wholly integrated, highly coordinated, and provider led model of care, POs ensure all care is person-centered, reflecting individuals' choices in where, how and from whom their care is provided. PACE often is the lifeline enabling enrolled people with disabilities and aging adults to live at home instead of in a nursing facility.

We commend Chairman Brownley and Ranking Member Bergman for holding this hearing as well as for convening previous hearings on the capability of the Department of Veterans Affairs (VA) to care for veterans as they age. The need for the VA to increase its ability to care for aging veterans was stated clearly by Dr. Teresa Boyd, VA Assistant Deputy Under Secretary for Health for Clinical Operations, during a March 2020 hearing before this Subcommittee:

> 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.

The VA has further estimated that of these aging veterans, roughly 80% will need long term services and supports; home and community based services (HCBS), including PACE, could meet many of those care demands. In a 2020 report, the Government Accountability Office (GAO) stated expenditures for long term care will more than double by fiscal year 2037 to $14.3B with the majority, $7.5B being spent on institutional care. And of those total expenditures, the percentage to be spent to meet the long term care needs of veterans with service-connected disabilities is projected to rise to 79% or $11.3B by 2037.

POs are proud to have veterans among their program participants. Historically, there has been an effort by the VA to increase the number of veterans receiving HCBS as an alternative to institutional care. The Veterans Health Administration first examined PACE through a successful All Inclusive Care Delivery Pilot during 2001 –2004. In 2010, as part of the VA-wide initiative to rebalance their provision of long-term care services and supports, the Patient-Centered Alternatives to Institutional Extended Care Program was implemented. From 2010 to 2012, twelve POs partnered with seven Veterans Affairs Medical Centers (VAMCs) to care for eligible veterans. By September 2014, 16 POs had contracted with their local VAMCs. Both the Pilot and the Program were effective in reducing utilization of hospital and nursing home care by elderly , frail veterans, increasing veteran satisfaction and heightening caregiver satisfaction.

However, since then, with the implementation of the Veterans Choice Program and its new contracting requirements coupled with limited and uncertain funding, it has been much more difficult for PACE organizations to sustain collaborations with local VAMCs or begin new ones. Today, only ten POs continue to partner with local VAMCs though Veterans Care Agreements, and the number of veterans enrolled as a result of those partnerships has decreased—despite the direction of The MISSION Act and the establishment of the Community Care Program to provide community-based care to veterans.

NPA believes substantially increasing the number of PACE organization – Veterans Affairs Medical Center (VAMC) partnerships can help the VA increase access to HCBS as well as decrease expenditures. During the prior Subcommittee hearing, Dr. Boyd acknowledged the clear desire for HCBS by veterans and the possible cost implications, stating "Veterans want to spend as much of their time as possible at home . . . . [t]hat means shifting resources to in-home programs. That will save us money on one side, but it's also the right thing to do for veterans and for their health."

The capitated and fully risk bearing payment model underlying PACE provides a strong incentive for PACE organizations to avoid duplicative or unnecessary services while encouraging the use of appropriate community-based alternatives to avoidable hospital and nursing home care. No service limits apply; PACE programs have the regulatory and financial autonomy to provide care and services as needed in the home, in the PACE centers and as needed in other settings such as physician offices, hospitals and nursing facilities.

Furthermore, expanding the use of PO-VAMC partnerships will help the VA address the three challenges to meeting the expected demand for long term care identified by GAO in 2020: workforce shortages, misaligned service locations to veterans' residences and lack of appropriate

long term care settings for veterans experiencing specialty care needs such as dementia care and behavioral health. Regarding workforce shortages, referring veterans to PACE will decrease the demand for services within the VA system overall. Geographically, across the 30 states in which POs are located, many are in traditionally underserved communities- both rural and urban. And PACE has demonstrated competencies in caring for older Americans with dementia and behavioral health conditions. Nearly half of all PACE participants (46%) live with dementia while depressive, bipolar and paranoid disorders are the second most common conditions experienced by PACE participants.

NPA remains deeply committed to supporting existing PACE-VAMC collaborations and facilitating new ones under the Veterans Community Care program, established by The MISSION Act of 2018 (P.L. 115-812). Our membership also remains eager to work with the VA and the Subcommittee to ensure continued and expanded access to HCBS for veterans through the PACE model of care. In closing, NPA thanks Chairman Brownley and Ranking Member Bergman for their strong, continued leadership on this vitally important issue.

Case Study

Mr. John Doe is a veteran enrolled in a PACE program, whose cost is covered by the U.S. Department of Veterans Affairs.

Social History

Mr. Doe continues to live safely with his wife, adult children, and a grandson on the lower level of his house. His wife is his primary care giver; his children are not involved in providing care. Mr. Doe requires extensive assistance for most of his Activities of Daily Living (ADLs) including bathing, dressing, toileting, transferring and walking. He feeds himself, and his wife assists him with all other ADLs. Mr. Doe uses a wheelchair for mobility and self-propels. He completes sit-to-stand transfers by himself.

Medical History

- 72 years of age; 195 lbs; BMI 28
- Multiple strokes with residual right sided paralysis
- Swallowing dysfunction requiring pre-diced food and thickened liquids
- Vascular dementia
- Chronic kidney disease
- Recurrent kidney stones
- Recurrent kidney infections
- Left kidney transplant in 20XX
- Coronary artery disease; coronary artery bypass via graft in 20XX; coronary angioplasty with stent in 20XX
- Diabetes
- Chronic obstructive pulmonary disease
- Arthritis/Degenerative Joint Disease- right shoulder
- Depression
- Anxiety
- PTSD
- Anger management issues
- Emotional impulsivity issues
- Displays poor safety awareness
- Tobacco user

In last six months, Mr. Doe has had three falls without injury, one inpatient hospitalization, and one skilled nursing facility stay.

Narrative

Mrs. Doe is Mr. Doe's primary caregiver. She is having difficulty adjusting to her spouse's lower functional level and there remains tension in the home due to the demands Mr. Doe places on his wife as a caregiver. Furthermore, Mrs. Doe continues to report her own physical limitations which create challenges and significant stress for her as a caregiver. As a result, PACE continues to provide twice daily care during the week and once daily on the weekends to assist Mrs. Doe. Mr. Doe also attends the PACE center four times a week. Additionally, Mr. Doe declined to implement medical nutrition therapy for his status post kidney transplant and diabetes. And while Mrs. Doe was recovering from surgery and unable to care for her spouse recently, Mr. Doe had a respite placement in a skilled nursing facility. His discharge after three months was delayed due to a bed bug infestation at the home, which has been resolved.

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