Jonathan B. Perlin, M.D., Ph.D. Under Secretary for Health U.S. Department of Veterans Affairs accompanied by: James F. Burris, M.D. Chief of Geriatrics

Statement of
The Honorable Jonathan Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health
Department of Veterans Affairs
On
VA's Long-Term Care Programs
Before the
Committee on Veterans' Affairs
United States Senate
May 12, 2005

Mr. Chairman and Members of the Committee:

Last month, I had the honor of appearing before you to discuss my nomination to become Under Secretary for Health for the Department of Veterans Affairs. Today, I am confirmed in that position?thanks to your support. I am grateful to every member of this Committee, both for your support and for your faith in me, and I am honored to work with you as we build a safe, effective, efficient, and compassionate health care system that will fully meet the needs of the men and women it is VA's privilege to serve.

Mr. Chairman, as you know, the Congressional Budget Office (CBO) recently testified before the Subcommittee on Health of the House Committee on Energy and Commerce about the cost and financing of long-term care (LTC) services. The CBO concluded that the demographic changes projected for the coming decades (i.e., the aging of the American population) will bring increased demand for long-term care and heightened Federal and State budgetary strains. CBO noted that the United States' elderly population will grow rapidly in coming decades, creating a surge in demand for LTC services, which already cost over $200 billion annually, including the value of donated care. CBO reported that financing patterns for LTC are heavily influenced by the rules governing public programs such as Medicare and Medicaid, which currently create disincentives to self-financing of LTC services. CBO also reported that since 1992, Medicaid spending for home-based care for seniors has grown faster than spending for institutional care, rising by about 11 percent annually, on average, compared with about three percent for care in nursing facilities.

Therefore, it is in this context, Mr. Chairman, that I express my appreciation to the Committee for this opportunity to continue its discussion with VA about the broad policy issues related to long-term care. In my statement today, I will talk first about the population that we serve in long-term care and how we prioritize that care. Then, I will discuss the newer models of non-institutional care and how we have progressed in our strategies to increase their use. Finally, I will address the broader dilemma of coordinating Federal and State long-term health care policy and what role VA should play in that effort.

First, let me discuss the population that we serve in VA's long-term care programs. As you know, the population of veterans who are enrolled for VA health care is, on average, older, poorer, and sicker than the general population. Thus, VA is already seeing the kinds of demographic changes

that the CBO projects for the country as a whole.
VA has testified previously that there is a great and growing need for long-term care services for elderly and disabled veterans. Between 2004 and 2012, the total number of enrolled veterans is projected to increase only 0.5 percent, from 7.37 million to 7.4 million. However, during this same time period, the number of enrolled veterans aged 65 and older is projected to increase 8.6 percent (from 3.44 million to 3.73 million). At the same time period, the number of enrolled veterans aged 85 and over will increase from 278,400 to 681,400, an increase of 145 percent. Looked at in another way, in FY 2004, 3.8 percent of all enrollees were ages 85 and over. In FY 2012, it is estimated that 9.2 percent of our total enrollment will be ages 85 and over. These veterans, particularly those over 85, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care, but also health care services of all types.
VA recognizes that we cannot, alone, definitively respond to the Nation's long-term care challenges. Nor can we meet the long-term care needs of every American veteran. What we can do is address the mandates set by Congress in Public Law 106-117 and prioritize care for those veterans most in need along the lines proposed in the President's FY 2006 budget submission.
In Public Law 106-117, the ?Veterans' Millennium Health Care and Benefits Act,? Congress mandated that VA provide medically necessary nursing home care to (1) those veterans who have a service-connected disability rated at 70 percent or more, and (2) any veteran in need of such care for a service-connected disability. I am proud to report VA is meeting this mandate. In FY 2004, VA provided over 2.7 million days of long-term care to 16,485 of these veterans in VA and community nursing homes. During this same period, an additional 208,474 days of long-term care were provided to 922 of these veterans in State Nursing Homes These data demonstrate that we are meeting all of the current demand and will meet all of the projected demand for nursing home care for these veterans whose care is authorized by statute and provided within the existing capacity of the three nursing home programs supported by VA.
The policy proposed in the President's FY 2006 budget submission goes beyond the requirements of Public Law 106-117. Under this proposed policy, VA will reach out to the broader veteran population, as resources permit, with the objective of providing medically necessary long-term care for veterans with compensable service-connected disabilities and for all other veterans with special needs. The special needs population includes veterans who have been traditionally challenged in finding optimal placement in the community due to the severity of their disabilities and the accompanying challenges that their care presents. Examples of these special needs patients include spinal cord injury patients, ventilator dependent patients, and chronically mentally ill patients. In addition, we believe it is appropriate and necessary for VA to provide short-term restorative care, respite, and hospice care for veterans in need of these services. In the interest of equity of access for all veterans, we would apply this policy equally to all venues of care supported by VA, its own Nursing Home Care Units, contract community nursing homes, and State Veterans Homes. We believe that the budget will support care for these additional, discretionary patients. This policy and the related costs have been thoroughly coordinated within the Administration.
Since many enrolled veterans are also eligible for LTC through other public and private programs, including Medicare, Medicaid, State Veterans Homes, and private insurance, it is in the interest of the both the government and veterans to coordinate the benefits of their various programs and work together toward a common goal, that of providing compassionate, high-quality care for the nation's older and more frail veterans. I want to emphasize that our efforts in long-term care case management are driven by the clinical needs of each patient, the patient's

preferences, and the benefit options available to that patient. VA health care providers work closely with patients and family, on a case-by-case basis, to coordinate the veteran's various Federal and State benefits, to maximize options for that veteran.

Next, I would like to discuss the newer models of non-institutional care that VA has embraced and how we have progressed in that regard. We in VA believe that long-term care services should be provided in the least restrictive setting compatible with a veteran's medical condition and personal circumstances. Whenever possible, veterans should be cared for in home and community-based non-institutional settings that help to maintain ties with the veteran's family, friends, and spiritual community. Nursing home care should be reserved for situations in which the veteran can no longer be maintained safely at home. Inevitably, many veterans will continue to require nursing home care. However, it is clear that VA alone cannot possibly provide nursing home care for all of the veterans projected to need such care over the next decade.

VA expects to meet much of the growing need for long-term care through care coordination, home health care, adult day health care, respite, home hospice and palliative care, and homemaker/home health aide services. In keeping with this patient-centered approach, VA has rapidly expanded its non-institutional services. The combined census in these programs, which grew by more than 20 per cent in FY 2004, is on target for at least an 18 percent increase in FY 2005 and is budgeted for an additional 18 per cent increase in the FY 2006 VA budget proposal. A substantial component of this increase in VA's non-institutional care services is attributable to the rapid expansion of Care Coordination. Care Coordination in VA involves the use of health informatics; telehealth and disease management technologies to enhance and extend existing care; and case management activities. VA's national Care Coordination initiative commenced in July 2003 and is supported by a national program office. Care Coordination enables appropriately selected veteran patients with chronic conditions (e.g. diabetes, heart failure, spinal cord injury, PTSD, and depression) to remain in their own homes, and it defers or obviates the need for long-term institutional care admission.

Veteran patients receiving Care Coordination are assessed on admission to a program and will be reassessed every three months thereafter to ensure institutional placement is made whenever it is indicated by a patient's functional status. The technology VA has selected for Care Coordination links care coordinators directly to patients in their place of residence. This continuous connection allows care coordinators to proactively institute clinical support from across the continuum of care and prevent avoidable deterioration in a patient's condition.

Local collaborations between Care Coordination and Advanced Clinic Access Programs help further expedite access to specialty care for these patients. A vital part of Care Coordination is ensuring that family members and other caregivers receive information and education to support their critical role in helping patients receive the right care in the right place at the right time. Care Coordination Programs have now been established in all 21 Veterans Integrated Service Networks (VISNs), and VA expects each Network's Care Coordination Program to reach a census of between 500 and 2,500 patients by the end of FY 2005, depending on the demographics, location, and density of the veteran population.

Care Coordination services have been created to link with existing home and community-based programs, including Home-based Primary Care (HBPC), Mental Health Intensive Case Management (MHICM), and General Primary and Ambulatory Care Services. The average daily census (ADC) in Care Coordination was 2,000 patients in FY 2002, is currently 5,800, and is projected to be 9,000 by the end of fiscal year 2005.

VA is committed to measuring the effectiveness of its care coordination program. Accordingly,

the VA Office of Research and Development, Health Services Program, includes a focus in its FY 2006 solicitation for projects that will:
? evaluate models for care coordination, making patients the focus of care, including transitions across outpatient, acute, residential, and home based care;
? examine methods to facilitate family and friends' involvement in the patient's LTC experiences;
? evaluate approaches to financial, transportation, administrative, and other barriers to LTC coordination; and
? explore how to maximize LTC facilities' use of findings or expertise from existing research centers in VA, academic, and clinical settings to enhance patient and caregiver quality of life.

In addition to advances through the Care Coordination program, VA also continues to make progress in expanding its more traditional home and community-based non-institutional care programs. From 1998 through the end of FY 2004, the ADC in these programs increased from 11,706 to 19,752. VA continues to have a VISN performance measure that calls for an additional 18 percent increase in the number of veterans receiving home and community-based care by the end of this fiscal year. This census is monitored in the Monthly Performance Report to the Secretary. Each VISN has been assigned targets for increases in their non-institutional LTC workload. VA is expanding both the services it provides directly and those it purchases from providers in the community.
Finally, Mr. Chairman, I would like to speak to the national discussion on long-term care and VA's role in that dialogue. Many of us in this room have possibly had to deal with trying to coordinate an approach to the long-term care needs of a loved one. I don't know anyone involved in such a situation who hasn't been frustrated by the complexities of the current multi-payer system ? however well intended the design might have been. The unfortunate reality is that the patchwork of benefits and payers was constructed around what was affordable and available -- as opposed to what was needed.
For its part, VA will continue to see large demographic shifts in population as the aging World War II population gives way to an aging Korean Era veteran population. Nationwide geographic shifts in population, from the north to the south, will continue to impact long-term care demand and the placement of services. Changing attitudes and preferences in the elderly population, such as elders' insistence on personal independence and self reliance, will affect the models of care offered. The economy plays an ever increasing role in life choices of the aging population. Changes in an individual's personal financial situation or changes in State economies may drive greater demand for Federal support in meeting the long-term care needs of the elderly.
Fortunately, I think that VA and Congress have developed a rational and effective system for meeting the long-term care needs of the highest priority veterans. I am thankful for your support in allowing us to explore new relationships, mechanisms, and technologies. It is this flexibility that has allowed us to reach out to greater numbers of veterans requiring long-term care. Given the challenges ahead, support for this flexibility is essential to ensuring that we can continue to maximize long-term care benefits for the enrolled population. While VA is ?ahead of the curve?, VA's approach to non-institutional care can serve as a national model useful in meeting societal needs of an aging population.
I think it is worth noting that the CBO report cited earlier in my testimony made no mention of VA long-term care benefits. Certainly, I would hope that any national dialogue would include discussion of the needs of veterans, including those enrolled for VA health care. It is important that veterans' needs are considered in this great national debate.

In conclusion, Mr. Chairman, let me leave you with the following summary of the basic elements in VA's plans for long-term care:
? an integrated care coordination system that incorporates all of the patient's clinical care needs;
? programs to support the provision of care in home and community-based settings whenever possible;
? a continued commitment to institutional care when this best serves the needs of the veteran;
? an emphasis on research and educational initiatives to improve delivery of services and outcomes for VA's elderly veteran patients; and
? computerization and advanced technologies to better provide patient-centered care, not only in the hospital, clinic, or long-term care facility, but also to support patients' successful aging and management of illness and facilities in their communities, in the context of their social and spousal relationships, and in their homes.

Mr. Chairman, this completes my statement. I will be happy to address any questions that you and other members of the Committee might have.