S. HRG. 109–240

AN OPEN DISCUSSION: PLANNING, PROVIDING, AND PAYING FOR VETERANS' LONG-TERM CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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MAY 12, 2005

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AN OPEN DISCUSSION: PLANNING, PROVIDING, AND PAYING FOR VETERANS' LONG-TERM CARE

THURSDAY, MAY 12, 2005

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry E. Craig (Chairman of the Committee) presiding.

Present: Senators Craig, Burr, Thune, Akaka, Rockefeller, Obama, and Salazar.

OPENING STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Chairman CRAIG. Well, good morning, ladies and gentlemen, and welcome to this hearing of the Committee on Veterans' Affairs. Today the Committee meets to explore and discuss the very important issue of long-term care for our Nation's veterans. It is no secret that for too many Americans, long-term care for elderly and disabled friends and relatives can quickly become the most expensive and emotionally difficult issue they will ever face.

Confronting those realities is no different for those who once wore the uniform of the United States Armed Forces and their families. Thirty-eight percent of veterans are over age 65, as compared to 12 percent in the general population, and the number of veterans over age 85 is expected to nearly double by 2012 to 1.3 million people. Given these basic statistics, it is not a stretch to say that dealing with long-term care is a bigger issue today among veterans and their families than any other group of Americans.

The Department of Veterans' Affairs is doing its part to provide some long-term care services to veterans enrolled for care. VA will spend nearly $2.4 billion this year providing institutional long-term care to 34,000 veterans each day. This care is provided not only in VA's 130 nursing home facilities, but also the 120 State veterans homes, as well as dozens of privately-owned facilities around the country. In addition, VA will spend nearly $300 million providing non-institutional long-term care to 26,000 veterans each day. These services range from adult day care to home-based primary care and basic care coordination.

Even with that extraordinary sum of money going to care for tens of thousands of veterans, VA is still merely scratching the surface of long-term care provided to our Nation's veterans. The Med-

icaid system, which is the shared Federal-State responsibility, captures the largest portion of long-term care services for this population. In fact, because many of the veterans never come to VA for care at all, we are unsure of just how many veterans Medicaid cares for.

Still, it is important to ask whether VA is providing the right services to the right people in the right setting. I think it is fair to say that VA believes it is not accomplishing that goal. They have proposed a series of changes in their long-term care program as part of the fiscal year 2006 budget. Two of those proposals—limiting per diem payments to certain patients in State veterans' homes, and establishing a moratorium on new home grants—would greatly impact the State veterans' home system. A third proposal to limit the population VA will serve will have significant implications on the Medicaid system and State budget coffers. Finally, a fourth proposal to greatly expand the non-institutional care program would ease financial and family burdens in a multiple of ways. Of course, all four of these proposals would impact the veterans who rely on VA for their health care services.

To begin the discussion over VA's long-term care proposal and the future needs of our veterans, I've assembled a group of witnesses who can speak on each or all of these issues. Joining us today to discuss VA's proposal is VA Under Secretary for Health, Dr. Jonathan Perlin. Also on Panel 1 to discuss State home programs is the president of the National Association of State Veterans Homes, Ms. Alfie Alvarado-Ramos. And finally, on Panel 1 to discuss long-term care more broadly, as well as Medicaid policy, is a well-respected expert in the field, Josh Wiener of RTI International. Welcome to all of you.

After the first panel, we will hear from two of the veterans' service organizations whose members have a great interest in long-term care services. Fred Cowell, who joins us from the Paralyzed Veterans of America, and Mr. Donald Mooney, will speak on behalf of the American Legion. And gentlemen, I trust that each of your comments will represent a broader population of veterans than just your two organizations. We welcome you as well.

I can't emphasize enough to my colleagues and those here today that long-term care is a very complicated problem facing American health care. Few of our citizens even consider planning for their own long-term care needs, and those who do are limited to a few insurance programs or just general savings. Many changes in these programs will, of course, greatly affect Federal and State budgets at a macro level. But more importantly, changes will likely affect individual veterans and their families on a very personal level. I hope our discussions today and in the future bear those realities in mind.

I've been joined, of course, by my colleague and the Ranking Member on the Democrat side, Senator Danny Akaka of Hawaii, and I'll turn to him for any opening comments he would like to make.

Good morning, Danny.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, RANKING MEMBER, U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you. Mr. Chairman, it is wonderful working with you. And it is wonderful that the Committee—and I have to give you credit for your leadership—working on critical issues such as this one on veterans' long-term care.

We truly must have an open discussion on who VA will care for and how VA will afford that care. It is a conversation which must occur throughout the Hill. After all, conversations about how to care for elderly family members occur every day in American homes.

But today, we are talking about veterans. We know that the need exists for veterans, yet the President's budget includes significant cuts to long-term care programs. The goal seems to be: reduce VA's workload and shift the burden elsewhere. Should VA be cutting back at a time when a demand is growing? Should these cuts target needed nursing home and State home beds? According to the President's budget proposal, the answer is yes.

VA nursing home care offers a level of service unparalleled in the community. VA sees patients who are increasingly difficult to place in the community—veterans with complex medical and mental health disorders. The State program is under attack as well. The Administration proposes to freeze grants for the construction of State veterans' homes and decreases the daily funding for these homes. The State home program has been described by members of both parties as incredibly cost effective. Still, these proposals imperil the very existence of these homes. While I am hopeful that these proposals will not become law, it signals a very disturbing trend.

There is another side to this story. There are places on the VA landscape where some truly wonderful things are happening to keep veterans well cared for and in the setting of their choice. Good programs must be fostered, but in the VA environment, long-term care services are frequently starved. Today, more and more veterans are seeking alternatives to nursing homes. They want to remain in the community. With the right kind of support and care from VA, they are able to do so, even with chronic and debilitating conditions.

For many veterans, however, non-institutional options will not work. And because this Congress is on record stating that VA must have sufficient nursing home capacity, it is vital that VA's role as a model for long-term care be recognized and rewarded, because we will have enormous problems with demand for this care in the years ahead.

The only entity with any scope, size, and capacity that is dealing with how to meet the needs of an older population is VA. This role of VA must be highlighted and supported. We look forward, of course, to working together to meet these challenges.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Danny, thank you very much.

We have been joined by our colleague, Richard Burr. Richard, do you have any opening comments you would like to make?

OPENING STATEMENT OF HON. RICHARD BURR, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Mr. Chairman, I would just like to thank you and the Ranking Member for taking on a discussion on long-term care. We will discuss long-term care as it relates to all of America. It will not be limited to veterans. But I can't think of a more important area for us to start this discussion to identify the challenges and, hopefully, find solutions to it.

And I would be remiss if I didn't welcome Dr. Perlin and congratulate him on his confirmation process. We are glad to have him on board.

Thank you, Mr. Chairman.

Chairman CRAIG. Richard, thank you. Well, you have said the right words. We have entitled this hearing "An Open Discussion: Planning, Providing, and Paying for Veterans' Long-Term Care." So, I think that is well-said and well-placed, Richard.

Let us turn to our first panel. Let me recognize once again Jonathan Perlin, Under Secretary for Health, U.S. Department of Veterans' Affairs. He is accompanied by James F. Burris—Dr. Burris, chief of geriatrics for the Veterans' Administration. Gentlemen, please proceed.

STATEMENT OF HON. JONATHAN B. PERLIN, M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS' AFFAIRS

Dr. PERLIN. Good morning, Mr. Chairman, Ranking Member Akaka, Members of the Committee, Senator Burr. Thank you very much for the opportunity to initiate this discussion. I want to thank you, Mr. Chairman, Ranking Member Akaka, in particular, for your advocacy, not only of veterans, but for all older Americans in having this hearing.

I also want to express my sincere appreciation for the support that you have all shown, voting to confirm me as Under Secretary for Health. I am truly honored to work with you to meet the health needs of the men and women for whom it is VA's great privilege to serve.

In addition to Dr. Burris, I am joined this morning, as well, by Mr. Art Klein who is our Director of Policy and Planning, and Dr. Adam Darkins who directs our Office of Care Coordination.

I appreciate the opportunity to continue our discussions about the broad policy issues related to long-term care. These important issues received added emphasis from the recent testimony of the Congressional Budget Office which concluded that the aging of the American population in the coming decades will bring increased demand for the long-term care and heightened Federal and State budgetary challenges. We in VA believe that long-term care should be provided in the least restrictive setting compatible with the veteran's medical condition and personal circumstances. Whenever possible, veterans should be cared for at home or in community-based non-institutional settings that help maintain ties with the veteran's family, friends, spiritual community as well.

Nursing home care should be reserved for those situations in which the veteran can no longer be maintained safely at home. Inevitably, many veterans will require nursing home care; however,

it is clear that VA alone cannot possibly provide nursing home care for all the veterans projected to need such care over the next decade. Although we are meeting all of the current demand and we will meet all of the projected demand for nursing home care for veterans mandated by statute, we must nevertheless prioritize care for those veterans most in need, along the lines of those proposed in the President's fiscal year 2006 budget submission.

Under this proposed policy, which still provides care to veterans well beyond the requirements of the law, VA will reach out to the broader veteran population as resources permit. We will provide medically necessary long-term care for veterans with compensable service-connected disabilities, for veterans with special needs, like spinal cord injury, serious mental illness, or ventilator dependence, and for veterans who require short-term restorative care, respite and hospice care has the first priority. VA expects to meet much of the growing need for long-term care through non-institutional services such as care coordination, home health care, adult day health care, respite, home hospice and palliative care, and homemaker/home health-aide services.

In keeping with its patient-centered approach, VA has rapidly expanded its combined census in these programs, which grew by more than 20 percent in fiscal year 2004. These programs are on target for at least an 18 percent increase in fiscal year 2005 and are budgeted for an additional 18 percent increase in fiscal year 2006. A substantial component of the increase is attributable to the rapid expansion of care coordination. Care coordination involves the use of health informatics, tele-health, and disease-management technologies and case-management activities to enhance and extend existing care. We now have care coordination programs in all 21 VA health care networks.

Mr. Chairman, VA and Congress have developed a rational, effective, and flexible system for meeting the long-term care needs of veterans. It is this very flexibility that has allowed us to reach out to a greater number of veterans requiring long-term care. Given the challenges ahead, support for the flexibility is essential to ensuring that we can continue to maximize long-term care benefits for the enrolled population. VA's approach to non-institutional care can provide and serve as a national model useful in meeting the needs of an aging population.

Mr. Chairman, if you would allow me to submit my full statement on this issue for the record, we would now be happy to address any questions that you or other Members of the Committee may have. Thank you.

[The prepared statement of Dr. Perlin follows:]

PREPARED STATEMENT OF HON. JONATHAN B. PERLIN, M.D., PH.D., UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS' AFFAIRS

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 of 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 3 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 fiscal year 2004, 3.8 percent of all enrollees were ages 85 and over. In fiscal year 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 fiscal year 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 fiscal year 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 vet-

erans, 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 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 percent in FY 2004, is on target for at least an 18 percent increase in FY 2005 and is budgeted for an additional 18 percent 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; tele-health 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 3 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 fiscal year 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 fiscal year 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.

Chairman CRAIG. Doctor, thank you very much.

We will now turn to Alfie Alvarado-Ramos, national president, the National Association of State Veterans Homes. Welcome to the committee. Please proceed.

STATEMENT OF LOURDES E. ALVARADO-RAMOS, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS' HOMES

Ms. ALVARADO-RAMOS. Thank you, Mr. Chairman.

Mr. Chairman, Senator Akaka, Members of the Committee, I appreciate the opportunity to testify today. My name is Alfie Alvarado-Ramos. I am the current president of the National Association of State Veterans' Homes, but my real job is as the assistant director of the Washington State Department of Veterans' Affairs. I am joined today by Gary Bermesolo, the administrator of the Nevada State Veterans Home and former director of State Veterans' Affairs for the State of Idaho; Phil Jean of the State of Maine, who is the immediate past president of NASVH; and Fritz Sganga, the executive director of the Long Island State Veterans' Home.

Chairman CRAIG. Well, we welcome them to the Committee. Thank you.

Ms. ALVARADO-RAMOS. Thank you.

As the largest provider of long-term care to our Nation's veterans, the State veterans' homes play an irreplaceable role in ensuring that eligible veterans receive the benefits, services, and quality long-term care that they have rightfully earned by their service and sacrifice to our country.

We greatly appreciate this Committee's commitment to the long-term care needs of our veterans, your understanding of the indispensable functions State veterans homes perform, and your strong support for our programs. We especially appreciate the support of this Committee in restoring funds to the 2006 budget to assure that per diem payments by the Department of Veterans' Affairs for veterans who are residents in our State homes will continue uninterrupted.

For nearly half a century State veterans' homes have operated under a VA program which supports the homes through construction grants and per diem payments. Both the VA construction grants and the per diem payments are essential components of a very cost-effective arrangement. In recent years, State veterans' homes have experienced a period of controlled growth. From 2000 to 2010, the number of veterans age 85 and older is expected to triple. Many of our homes have occupancy rates of 100 percent, or nearly 100 percent, and some have waiting lists. It is critical that the construction grant program be sustained in order to meet this growing need.

In your letter of invitation, Mr. Chairman, you asked how the State homes can better assist VA in providing long-term care. Our vision is State veterans' homes working closely with the VA to provide a full continuum of care to veterans. According to a recent GAO report, the VA is currently utilizing one-third of its nursing home beds for extended space. We believe the VA could shift more of its long-term care and other specialty services to the State homes and ultimately increase the capacity of VA to provide short-term specialized care. The average cost for care at a VA long-term

care facility has been calculated nationally to be over $420 per day. The cost of care to the VA for the placement of a veteran at a community contract home is approximately $195 per day. The same daily cost to the VA long-term care at a State home is only $59 per day.

Mr. Chairman, I recently wrote a letter to Secretary Nicholson on this topic, and I respectfully ask that a copy of this letter be inserted in the hearing for the record.

Chairman CRAIG. Without objection, it will become part of our record.

[The letter follows:]

APRIL 5, 2005

HON. JAMES NICHOLSON, *Secretary,*
Department of Veterans' Affairs,
810 Vermont Ave., NW,
Washington, DC 20420.

DEAR SECRETARY NICHOLSON: On behalf of the National Association of State Veterans Homes (NASVH), thank you for meeting with Roy Griffith (OK), Fred Sganga (NY), and me (WA) on February 21, 2005. At that time, I assured you that we would follow up with written comments not only about our discussion of the President's FY 2006 budget, but also on our thoughts about how the State Veterans Homes Program can play an increasing role in meeting the future needs of our veterans.

NASVH is an organization without a headquarters or administrative support staff. Those who lead the organization are not paid employees. Most Veterans Homes administrators are veterans, who belong to, and support, this organization out of our love and respect for those who served our country and their need for a dignified end of life.

Our 119 Veterans Homes, with over 27,000 beds, are a resource to the VA and an example of a successful, more than 100-year-old, Federal-State partnership. Yet, the President's proposed budget for FY 2006 dismisses their potential for helping realize the VA's vision of establishing a continuum of care. NASVH is an organization that constantly monitors the evolution of long-term care. We want to be a real partner with the VA to develop and implement solutions that will give our veterans the best options for quality long-term care at the most reasonable cost.

We appreciate your personal recognition of this partnership as reflected in your recent comment regarding a construction grant for improvements to the Missouri Veterans Home in St. Louis—"This grant reflects the Federal-State partnership that is honoring our commitment to care for the men and women who have served in uniform. The partnership provides a comfortable home for veterans in a time of great personal need."

The State Veterans Home Program represents over 51 percent of the VA's total long-term care workload. We provide services to the most frail and medically-compromised veterans at a cost to the VA of about $59 per day, well below the cost of care in a VA nursing home, which exceeds $400. We recognize that the higher cost reflects, in part, the VA's transition to rehabilitative care and decreased maintenance care. The same transition is taking place in many State Veterans Homes nationwide. Our acuity is rising, the lengths of stay are declining, and the mental health challenges presented by our residents are becoming more complex.

The Millennium Veterans Health Care Act brought significant changes to VA long-term care in 2000. As veterans 70 percent service-connected and above became entitled to long-term care, NASVH asked for its rightful place to provide care to this population, under similar conditions as contract community homes. This would have resulted in the veteran retaining his/her income, while VA would set a reasonable rate to compensate the homes for services. We believe that we are extremely competitive and could have saved the VA contract dollars over the past few years. Unfortunately, the VA's General Counsel ruled that VA could not enter into a contract with our homes under the current terms of the Act. This is an issue we would like to reopen, as we know it can be fixed.

VA established an Assisted Living pilot which took place in VISN 20 that is about to expire. Again, due to rigid contracting rules and legal opinions, the State Veterans Homes Program was excluded from that continuum of care option. In Washington State, for example, we could have banked nursing home beds so as not to "double dip" in per diem and contract dollars, and we could have saved significant VA social work staff hours and operating capital.

The State Veterans Homes Program is a resource, not a burden. We have proposed, and continue to propose, that our beds be counted toward your overall long-term care census. This will allow the VA to meet the Millennium Health Care Act's long-term care bed requirements. We respectfully request that we approach this issue together to demonstrate to Congress that a nursing home bed in a State Veterans Home is as viable, and more economical, than a nursing home bed in a VA hospital. The object is to not only provide care in a quality manner, but to also expand the VA's capacity to provide services without increasing cost. The result could allow the VA to meet its legislative mandate, shift its maintenance care and other specialty services to the State Homes, and ultimately increase its capacity to care for short stay, highly-specialized rehabilitation care.

NASVH continues to offer its assistance to Geriatrics and Extended Care in the area of regulatory reform. It can take years to develop and implement rules because of turnover and personnel shortages in Geriatrics and Extended Care. NASVH enjoys a good working relationship with the staff. Again, we offer our expertise, unconditionally, to assist in the drafting of much needed rules, like Domiciliary Care. We believe that we can assist in decreasing the development time, augment your staff's capacity, and help the Department promulgate sensible rules.

NASVH recognizes and supports the national trend towards deinstitutionalization and the provision of long-term care at the most independent and cost-effective setting. We believe this is why the VA should involve NASVH as a full partner in the development and implementation of programs such as Hospice, Home Health, Adult Day Care and Gero-Psychiatric care under the Per Diem Grant and Palliative Care Programs. VA pays significant contract dollars for palliative care, and we know that with our expertise in caring for veterans and their unique issues, we can provide quality care in alternative settings if given the opportunity. This will require a flexible approach towards the establishment of pilot programs that will allow both the VA and State Veterans Homes to experiment with a variety of institutional and non-institutional settings and per diem rates.

In our meeting, we also discussed the impact of the proposed legislation that restricts the payment of the VA per diem to Priorities 1, 2, 3, and 4 (Catastrophically Disabled). With respect to the latter category, NASVH has experienced significant challenges in pinpointing who qualifies as "catastrophically disabled." There are many inconsistencies between the revised VA's Geriatrics and Extended Care long-term care policy in the congressional budget submission and the latest clarification made by the VA's Chief Financial Officer. This has made it virtually impossible to get an accurate assessment of the proposed legislation's impact. To complicate matters, some VA Medical Centers claimed not to have the information available while others were very accommodating. This should not occur if we are a true partner in the VA's continuum of care. We ask for your assistance in overcoming the barriers that prevent critical information sharing.

It is our best estimate that the proposed change in eligibility for the per diem would result in about 80 percent of the veterans in our homes being disqualified for the nursing care per diem and the loss of over $300 million in operating funds to State Veterans Homes nationwide. This loss would affect approximately 15,000 of our 19,000 nursing-home-care residents. We assume that the VA believes that these veterans, if not able to remain in our homes, will somehow be picked up by State systems. It has been our experience that many residents were referred to our homes by those systems because the individuals were difficult to manage. Veterans often present histories of chronic heart, diabetes, and respiratory diseases coupled with homelessness, incarceration, poly-substance abuse, and/or mental health illnesses that relate to their service. These residents have been able to thrive and remain at their highest level of function because of our superior medical and mental health care and the supportive environment our homes provide.

Finally, we believe it is important to underscore the factors that make the State Veterans Program the ideal alternative for our heroes' long-term care:

- Veterans Homes provide residents with a sense of community and tradition that dates back to their active service.
- Veterans have a common experience related to their service and provide peer support to each other. Many veterans come to our homes following long-term homelessness, chronic depression, mental illness, and substance abuse. This structure fortifies their spirit and allows them to thrive despite failures in other community settings.
- Our homes attract quality employees who are dedicated to serving this worthy group of men and women. We also attract caregivers who are themselves veterans and who provide an enhanced level of care because of their own service.
- Veterans Homes celebrate our residents' service every day, not just in annual observances.

• Residents in Veterans Homes receive tangible and consistent daily support from the military and Veterans Service Organizations. These organizations provide thousands of volunteer hours at the Homes, and also host outside activities tailored to our veterans.
• State Home employees understand and are trained to manage the behaviors and idiosyncrasies that veterans exhibit as a result of their exposure to combat or military service stress.
• Families choose an environment that honors what their loved ones are most proud of—their service to country.
• At the point where there is no other non-institutional alternative, some veterans will not go to a "nursing home," but they will accept admission to a Veterans Home. They served with their peers and often prefer to spend their last days with their peers, as well.
• Since the Veterans Homes are VA partners, we are better able to coordinate benefits not only for veterans, but also for their families in the community.

We believe the VA should consider the State Veterans Homes as a resource, not a burden. NASVH is open to explore every option that will give veterans the quality of life they have earned. This will require creativity, flexibility, openness, and inclusiveness. We have made small gains in past endeavors, but our greatest challenge is upon us today. Our State Veterans Homes cannot be a resource, and may not survive, if the President's proposed changes in the per diem go into effect. We urge you to give us the opportunity to be at the table so that we can provide our expertise in the laborious planning required to provide all our veterans a place to call home.

Sincerely,

LOURDES E. ALVARADO-RAMOS,
President.

Ms. ALVARADO-RAMOS. Under current law, strict limits and standards control the construction or renovation of State homes according to need. This process assures that new State homes are built only in those States that have the greatest unmet need. The VA has identified 10 States as having either great or significant need to build new State homes immediate. They include Texas, Pennsylvania, and Hawaii, which expects to open its first State home next year. As the Committee knows, the Administration's budget would have imposed a moratorium on construction grants and would have slashed per diem payments by revising the eligibility requirements.

State taxpayers have paid hundreds of millions of dollars to help construct, maintain, and operate State homes. The budget would have abruptly and needlessly abandoned this partnership and placed the States in an untenable financial position leading to the ultimate closure of many State homes. On behalf of the Veterans we serve, thank you for rejecting the proposal to do this. We appreciate what you have done for our homes.

In conclusion, Mr. Chairman, I reiterate the key issues facing the State homes. First, the per diem eligibility rules should be preserved. Second, we believe the Committee and Congress should reject the moratorium on State home construction. And third, the State homes should gain a more substantial role in planning the future of long-term care for veterans. With this Committee's support, the National Association of State Veterans' Homes is anxious, ready, and willing to work with the VA to explore innovative ways to meet the needs of America's aging veteran population.

Thank you again to the Committee for your diligent work. I will be happy to answer any questions you may have.

[The prepared statement of Ms. Alvarado-Ramos follows:]

PREPARED STATEMENT OF LOURDES E. ALVARADO-RAMOS, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS' HOMES

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on behalf of the National Association of State Veterans' Homes ("NASVH") on access to and the availability of long-term care services for our Nation's veterans. I am the Assistant Director of the Washington State Department of Veterans Affairs, and I serve as the 2004–2005 President of NASVH.

The State Veterans Homes program is the largest provider of long-term care to our Nation's veterans. As such, the State Veterans Homes play an irreplaceable role in ensuring that eligible veterans receive the benefits, services, and quality long-term health care that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate this Committee's commitment to the long-term care needs of veterans, your understanding of the indispensable function that State Veterans Homes perform, and your strong support for our programs.

We especially appreciate the support of this Committee in restoring funds to the FY 2006 budget resolution to assure that per diem payments by the Department of Veterans Affairs ("VA") to veterans who are residents in our State Homes will continue uninterrupted.

The membership of NASVH consists of the administrators and staff of State-operated veterans homes throughout the United States. We currently operate 119 veterans' homes in 47 States and the Commonwealth of Puerto Rico. Nursing home care is provided in 114 homes, domiciliary care in 52 homes, and hospital-type care in 5 homes. These homes presently provide over 27,500 resident beds for veterans of which more than 21,000 are nursing home beds. These beds represent about 50 percent of the long-term care workload for the VA.

We work closely with the VA, State governments, the National Association of State Directors of Veterans Affairs, veterans service organizations, and other entities dedicated to the long-term care of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meet or exceed the highest standards available.

ROLE OF THE STATE VETERANS' HOMES

State Veterans Homes first began serving veterans after the Civil War. Faced with a large number of soldiers and sailors in critical need of long-term care, several States established veterans' homes to care for those who served in the military.

In 1888, Congress first authorized Federal grants-in-aid to States that maintained homes in which American soldiers and sailors received long-term care. At the time, the payments amounted to about 30 cents per resident per day. In the years since, Congress has made several major revisions to the State Veterans Homes program to expand the base of payments to include nursing home, domiciliary, and adult day health care.

For nearly half a century, State Veterans Homes have operated under a program administered by the VA which supports the Homes through construction grants and per diem payments. Both the VA construction grants and the VA per diem payments are essential components of this support. Each State Veterans Home must meet stringent VA-prescribed standards of care, which exceed standards mandated by Federal and State governments for other long-term care facilities. The VA conducts annual inspections to ensure that these standards are met and to ensure the proper disbursement of funds. Together, the VA and the State Homes represent a very effective and financially-efficient Federal-State partnership in the service of our veterans.

VA per diem payments to State Homes are authorized by 38 U.S.C. § 1741–1743. Congress intended to assist the States in providing for the higher level of care and treatment required for eligible veterans residing in State Veterans Homes. As you know, the per diem rates are established by the VA annually and may not exceed 50 percent of the cost of care. They are currently $59.36 per day for nursing home care, $35.17 per day for adult day health care, and $27.44 per day for domiciliary care. Our State Veterans Homes cannot operate without the per diem payments from the VA.

Construction grants are authorized by 38 U.S.C. § 8131–8137. The objective of such grants is to assist the States in constructing or acquiring State Veterans Home facilities. Construction grants are also utilized to renovate existing facilities and to ensure continuing compliance with life safety and building codes. Construction grants made by the VA may not exceed 65 percent of the estimated cost of construction or renovation of facilities, including the provision of initial equipment for any project. State funding covers at least 35 percent of the cost. Our program cannot meet our veterans' needs without an adequate level of construction grant funding.

In recent years, State Veterans Homes have experienced a period of controlled growth—the result of increasing numbers of elderly veterans who have reached that point in life when long-term care is needed. In fact, we face the largest aging veterans population in our Nation's history. From 2000 to 2010, the number of veterans aged 85 and older is expected to triple from 422,000 to 1.3 million. If the State Veterans Homes program is to fill even a part of this unmet need for long-term care beds in certain States, and to respond to the increase in the number of veterans eligible for such care nationally, it is critical that the construction grant program be sustained.

The State Veterans Home program now provides about 50 percent of the VA's total long-term care workload. The VA recently estimated that nursing care beds in the State Homes are 87 percent occupied. Many of our Homes have occupancy rates near 100 percent, and some have long waiting lists. The State Veterans Homes provide long-term medical services to frail, elderly veterans at a cost to the VA of only $59 per day, well below the cost of care in a VA nursing home, which exceeds $400 per day.

Although there are no national admission requirements for the State Veterans Homes, there are State-by-State medical requirements for admission. Generally, a State will demand a medical certification confirming significant deficits in activities of daily living (an assessment of basic functions) that require 24-hour nursing care. Moreover, no per diem is paid by the VA unless and until a VA official certifies that nursing home care is required. Such veterans are almost always chronically ill and elderly, and many are afflicted with mental health conditions.

STATE VETERANS' HOMES AS A VA RESOURCE

The Veterans' Millennium Health Care Act ("Mill Bill"), Pub. L. No. 106–117, brought significant changes to veterans' long-term health care. Significantly, the VA is directed to provide long-term care for all veterans who have a 70 percent or greater service-connected disability or who need nursing care for a service-connected disability. The State Veterans Homes should play a major role in meeting these requirements and be treated as a resource integrated more fully with the VA long-term care program.

We have proposed that our beds be counted toward the VA's overall long-term care census. Doing so would allow the VA to meet the Mill Bill's long-term care bed requirements. A nursing home bed in a State Veterans Home is an economical alternative to a nursing home bed in a VA-operated facility. Congress's goal should be to provide long-term care to veterans in a manner that expands the VA's capacity to provide services without increasing cost. Including State Veterans Homes nursing beds in the mandated VA long-term care totals could allow the VA to meet its legislative mandate, shift some of its maintenance care and other specialty services to the State Veterans Homes, and ultimately increase the capacity of the VA to provide greater short stay, highly-specialized rehabilitative care.

This goal can be accomplished by the State Homes at substantially less cost to taxpayers. The average daily cost of care for a veteran at a long-term care facility run directly by the VA has been calculated nationally to be $423.40 per day. The cost of care to the VA for the placement of a veteran at a contract nursing home, which does not need to meet the same VA standards is approximately $194.90 per day. The same daily cost to the VA to provide long-term care at a State Veterans Home is far less—only $59.36 per day for nursing care.

This substantially lower daily cost to the VA of the State Veterans Homes compared to other available long-term care alternatives led the VA Office of Inspector General to conclude in a 1999 report:

> The SVH [State Veterans Home] program provides an economical alternative to Contract Nursing Home (CNH) placements, and VAMC [VA Medical Center] Nursing Home Care Unit (NHCU) care (emphasis added).

In this same report, the VA Office of Inspector General went on to say:

> A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long-term care patients to community-based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

VA CONSTRUCTION GRANT PROGRAM

Under current law, there are strict limits and standards for funding the construction and renovation of State Veterans Homes. The system is working very well under the provisions of the Mill Bill, which establishes priorities for funding according to life/safety, great need, significant need, and limited need. Pursuant to these standards, in FY 2005, only 35 priority construction or renovation projects have been authorized and are underway in Wisconsin, Nebraska, Ohio, New Hampshire, New York, Michigan, Massachusetts, Connecticut, Hawaii, Alaska, Delaware, Rhode Island, Oklahoma, Florida, North Carolina, Colorado, Georgia, Missouri, and Minnesota. Other projects in these and other States have been approved initially for FY 2006 funding by the VA.

Specifically, the VA has identified 10 States as having either a "great" or "significant" need to build new State Veterans Homes beds immediately. These are Florida, Texas, California, Pennsylvania, Ohio, New York, Hawaii, Delaware, Wyoming, and Alaska. Hawaii expects to open its first State Home next year. Florida has five new homes in the planning stages, and Texas has four homes in the planning stages and two homes in the final stages of construction. California has three new homes approved. Delaware and Alaska are planning their first State Homes. The needs of veterans in these States require that these facilities be built.

Moreover, under the requirements of the Mill Bill, the VA prescribes strict limits on the maximum number of State Veterans Home nursing beds that may be funded by construction grants. This is based on projected demand for the year 2009, which determines which States have the greatest need for additional beds. This process assures that additional State Veterans Home beds are built only in those States that have the greatest unmet need for such beds.

VA BUDGET PROPOSAL FOR FY 2006

The President's FY 2006 budget would devastate the State Veterans Homes program and deny care to the thousands of veterans who currently utilize the program and the tens of thousands of veterans who will need the program in the future. The budget proposal would: (1) slash per diem payments by revising the eligibility requirements for the State Veterans Homes so that the vast majority of veterans suddenly would be ruled ineligible for per diem benefits; and (2) impose a moratorium on construction grants, terminating plans for many new Homes, life/safety projects, and renovations where a need has been justified in many key States under the standards of the Mill Bill.

The change in the per diem criteria would have the most immediate impact on the State Homes program. Under the President's proposal, per diem payments for nursing care at State Veterans Homes would be limited to veterans in priorities 1–3 and those in priority 4 who are catastrophically disabled (a new and poorly-defined concept of disability).

NASVH concludes, based on a poll of our members, that the Administration's budget proposal would rule ineligible approximately 80 percent of the current population of the State Veterans Homes. More than 14,000 of the 19,000 veterans in State Veterans Homes would be denied the per diem benefit. This analysis examined the current population of the State Homes. The VA has proposed grandfathering current residents, but that will only delay the full impact of the proposal for months, not years, because we estimate that most current residents of the State Veterans Homes will pass away or be discharged within 12 to 18 months.

The President's proposed budget abrogates the Federal Government's commitment to the State Veterans Homes program. State taxpayers have paid hundreds of millions of dollars to help construct the State Veterans Homes with the understanding that the Homes would continue to serve the veterans population. However, the President's budget abruptly and needlessly abandons this arrangement and places the Homes in an untenable financial position. Simply put, it could lead to the closure of many State Homes.

We applaud the Senate Veterans' Affairs Committee for rejecting the proposed cuts to the per diem payments. Mr. Chairman, thank you for stating, in your "views and estimates" letter on behalf of the Republicans on the Committee, that "severe restrictions in per diem support for State homes is, in my estimation, an unsound idea" and for concluding that "I cannot endorse a cutting of per diem assistance to State homes to which needy veterans will increasingly turn for care."

Senator Akaka and your Democratic colleagues, we are grateful that your "views and estimates" letter likewise expressed support for the per diem program and concluded that "It is our view that eligibility for per diem payments to [State Veterans Homes] should remain intact."

Moreover, NASVH was pleased that the FY 2006 budget resolution rejected the per diem cuts, thanks to the amendment offered by Chairman Craig and Senators Ensign, Hutchison, and Vitter and the work of many Senators during the conference committee.

CONCLUSION

Thank you for your commitment to long-term care for veterans and for your support of the State Veterans Homes as a central component of that care. In conclusion, I will reiterate the key issues facing the State Veterans Homes.

First, with respect to the President's proposal for cuts to the per diem, we hope to continue working with the Members of this Committee and the Appropriations Committee to ensure that the VA appropriations bill reflects the consensus that led to a Budget Resolution that preserves sufficient funds for continued per diem payments under current eligibility requirements. We also seek your assistance in directing the Administration not to impose unilateral changes to VA per diem payments through administrative means.

Second, we believe the Committee and the Congress should reject the moratorium on State Veterans Homes construction grants, many of which fund needed renovations for life/safety issues or address demonstrated need in certain States for more nursing-care beds.

Third, we believe that the State Veterans Homes can play a more substantial role in meeting the long-term care needs of veterans. NASVH recognizes and supports the national trend towards de-institutionalization and the provision of long-term care in the most independent and cost-effective setting. In a letter to VA Secretary Nicholson dated April 5, 2005, NASVH proposed that we explore together creative ways to provide a true continuum of care to our veterans both in our Homes and in the community. We would be pleased to work with the Committee and the VA to explore options for developing pilot programs for innovative care and for more closely integrating the State Veterans Homes program into the VA's overall health care system for veterans.

Chairman CRAIG. Ms. Ramos, thank you very much.

Let us turn now to Josh Wiener, Ph.D., Senior Fellow, Program Director for Again, Disability and Long-Term Care at the RTI International.

Senator BURR. Mr. Chairman.

Chairman CRAIG. Yes.

Senator BURR. Before Dr. Wiener is recognized, may I take this opportunity—I should have read it when I came in—to welcome him.

Chairman CRAIG. Of course.

Senator BURR. The Research Triangle Institute, for the purposes of my colleague's——

Chairman CRAIG. That is what "RTI" stands for?

Senator BURR. That is correct.

Chairman CRAIG. Please tell us about it.

Senator BURR. Since it is in the first part of his testimony, let me share with you that this is the brainchild of the founding fathers in North Carolina in the late 1950s at a part of our State which—most of us know the Research Triangle Park and the great work of technology that is done there. They saw the need early on to have a nonprofit established there that is multifaceted and multitalented. They enter into tremendous contracts with the Federal Government, with other countries around the world in too numerous of fashions for me to describe.

But we have with us today a senior fellow, somebody who is well-versed in long-term care, the author of eight books, over 100 articles, a commitment that has served on advisory boards, including the VA. I think it is a tremendous opportunity for us to hear from him today, and I welcome you, Doctor.

Chairman CRAIG. Well, with that, Doctor, would you please proceed?

STATEMENT OF JOSH WIENER, SENIOR FELLOW, PROGRAM DIRECTOR FOR AGING, DISABILITY, AND LONG-TERM CARE, RTI INTERNATIONAL

MR. WIENER. Mr. Chairman and Members of the Committee, thank you for this opportunity to testify today on long-term care for America's veterans.

Like the rest of America, the veterans population is aging and with it the prevalence of disability is increasing. As the chairman noted, the veterans' population age 85 and older, the population most likely to need long-term care, is projected to double within the next 10 years. The prevalence of disability among the enrolled VA population is substantially higher than among the non-veteran population, and sadly, injuries to soldiers in Iraq will add to the demand for long-term care.

Although the large majority of veterans receive services outside of the VA, VA has an extensive and distinguished history of providing long-term care services. In this environment, the Administration is proposing to reduce funding for VA long-term care services by $378 million, about 10 percent. If enacted, the Administration's changes will reduce the availability of long-term care services in the VA. More veterans will have to obtain services in the general community or go without.

Thus, a key policy question is what long-term care services are available in the community, and how are they financed? In terms of services, there is a large supply of community nursing homes currently with relatively low occupancy rates, around 86 percent. There are substantial numbers of home-health and home-care agencies, but both institutional and non-institutional services in the community, as well as in the VA, are threatened by an increasing workforce shortage caused in large part by low wages and benefits.

In terms of financing, long-term care is financed by a mix of public and private resources, including Medicare, which is primarily an acute care program, but covers nursing home care and home health care. It does not, however, cover long-term care. The nursing home care and home-health benefits under Medicare are geared to short-term post-hospital care and are very skilled and rehabilitation-oriented services. Importantly, Medicare services are available without a means test.

A second factor in terms of financing is private long-term care insurance. This role is very small, but currently growing. About 9 percent of the population age 55 and older has some kind of private long-term care insurance. Much less than 1 percent of the population under 55 has some kind of insurance. The major barrier to the growth of long-term care insurance is cost. A good-quality policy bought at age 65 averages about $2,862 per year.

Since private insurance and Medicare do not cover long-term care to a significant extent, a major source of financing for long-term care is out-of-pocket costs by individuals. And long-term care is expensive. The average cost of a year in a nursing home is about $62,000 a year.

Medicaid, however, the Federal-State health care program for the poor, is the dominant source of financing for long-term care. Two-thirds of nursing home residents depend on it to pay for their care. Medicaid is a strictly means-tested program limited to people who are poor or people who become poor because of the high cost of long-term care services. States have great flexibility in designing and administering the program, so services and disability and financial eligibility standards vary greatly across States.

There are also a wide variety of other Federal and State programs, mostly means-tested in some way, that finance primarily home-care services.

So, in conclusion, first, for both veterans and general population, the demand for long-term care is certain to increase sharply over time. The United States does not have a coherent plan for dealing with the aging of the population. While Social Security and Medicare have received substantial attention, long-term care has been ignored.

Overall, second, many current nursing homes have excess capacity that could, at least theoretically, absorb the reduced demand by the Department of Veterans' Affairs-funded facilities. Whether the excess capacity and the reduced Department of Veterans' Affairs capacity are in the same locations or are serving the same types of populations is unknown. Overall—and I think this is highly important—the growth of long-term care services in the VA and outside is likely to be impeded by this workforce shortage that is almost certainly to grow dramatically worse over time.

Third, although the supply of home- and community-based services has increased in both the overall system and within the VA, there remains a strong institutional bias, which is stronger in the VA than in the general community. The VA is working to change this, and the Administration's proposals do call for an increased funding for home- and community-based services.

Fourth, the current financing for long-term care and acute care services is highly fragmented with multiple funding sources and a lack of integration between acute and long-term care services. The potential for better integration is probably better in the VA than in the general community.

Fifth, current financing of long-term care is dominated by public programs and that is likely to remain so in the future. Private-sector programs are unlikely to become a dominant source of financing.

And finally, Medicare is the dominant source of funding for long-term care. It is strictly means-tested. Initiatives to reduce Department of Veterans' Affairs funding for long-term care is likely to increase Medicaid expenditures at a time when States are still experiencing fiscal difficulties.

In conclusion, again, America does not have a serious plan for dealing with long-term care. It has not started a debate on how to deal with an aging population. It is time to begin that debate.

Thank you.

[The prepared statement of Mr. Wiener follows:]

PREPARED STATEMENT OF JOSH WIENER, SENIOR FELLOW, PROGRAM DIRECTOR FOR AGING, DISABILITY, AND LONG-TERM CARE, RTI INTERNATIONAL

Mr. Chairman and Members of the Committee, I am pleased to testify today on the subject of long-term care for America's veterans. I am Joshua M. Wiener, Ph.D., senior fellow and program director for aging, disability, and long-term care at RTI International, a nonprofit research organization headquartered in Research Triangle Park, North Carolina. I am the author or editor of 8 books and over 100 articles on long-term care, aging, Medicaid, disability, end-of-life care, and health reform in the United States and abroad. In 1997 and 1998, I was a member of the Federal Advisory Committee on the Future of Long-Term Care in the VA. The opinions that I express today are my own and do not necessarily represent the views of RTI International.

Like the rest of America, the veteran population is aging, and with it, the prevalence of disability is increasing. In 2002, there were approximately 10 million veterans age 65 or older (Department of Veterans' Affairs, undated). Even more important for long-term care is that the veteran population age 85 or older is projected to increase from 640,000 in 2002 to 1.3 million in 2012 (U.S. General Accounting Office, 2003). Disability and the need for long-term care services are closely linked to age, with much higher needs at older ages. For example, almost half of the Nation's nursing home population is age 85 or older.

In addition, the population served by the Department of Veterans' Affairs has a high level of disability. According to the 2002 survey of veterans enrolled with the Department of Veterans' Affairs for health care, 51 percent of older people reported problems with the activities of daily living or instrumental activities of daily living, and 6 percent reported problems with three or more activities of daily living, a prevalence level far higher than that of the general population (Department of Veterans' Affairs, 2003; Manton and Gu, 2001). A large research literature finds that people with disabilities have higher levels of acute care and long-term care use than persons without disabilities (Alecxih, Corea, and Kennell, 1995).

Against the backdrop of increasing need for long-term care services, the Administration's fiscal year 2006 budget proposes cutting back on Department of Veterans' Affairs long-term care services. These proposals include a reduction in the number of Department of Veterans' Affairs-provided nursing home beds, as well as a plan to limit geriatric nursing home care to service-connected conditions, catastrophically disabled persons (e.g., spinal cord injured veterans), and veterans who are at least 70 percent service-connected disabled. In addition, per diem payments and new grants for State veterans' homes would be further limited.

If enacted, these changes will reduce the availability of long-term care services in the Department of Veterans' Affairs; veterans will have to obtain services in the general community and use other financing mechanisms or go without services. The key policy question is: Outside of the Department of Veterans' Affairs, what long-term care services are available and how are they financed, and what are the implications for veterans and third-party payers of using services outside of the Department of Veterans' Affairs system?

BACKGROUND

To help meet the long-term care needs of veterans with disabilities, the Department of Veterans' Affairs has a long history of providing long-term care services. Long-term care is the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic tasks of everyday living, such as eating, bathing, dressing, and housekeeping (Wiener, Illston, and Hanley, 1994). Although not as extensively provided as other services, the Department of Veterans Affairs provides nursing home care (in Department of Veterans' Affairs-operated units, contract community nursing homes, and State veterans' homes), home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, community residential care, respite care, home hospice care, and domiciliary care (Department of Veterans' Affairs, 2005b).

In fiscal year 2005, the Department of Veterans' Affairs will spend about $3.6 billion on long-term care, approximately 91 percent of which is for nursing home services (Department of Veterans' Affairs, 2005a). Although the supply of VA-financed home and community-based services has increased in recent years, a General Accounting Office (2003) study found substantial variation across the country in the availability of services. Variation in availability of services and restrictions on the amount of services make it difficult for these home and community-based services to function as alternatives to nursing home care. Overall, the Department of Veterans' Affairs finances about 3 percent of the nation's spending on long-term care services for older people and accounts for about 2 percent of the Nation's nursing

home population (American Health Care Association, 2005a; Congressional Budget Office, 2004). A majority of veterans receive their care outside of the Department of Veterans' Affairs system.

NON-VA LONG-TERM CARE SERVICES

In terms of services, there are approximately 1.7 million nursing home beds in 16,000 facilities in the United States (American Health Care Association, 2005b). Current occupancy rates are at unprecedented low levels, averaging about 85.5 percent nationally (although rates vary greatly across geographic areas). In recent years, there has been a substantial growth in assisted living facilities, which are residential settings that provide personal care (e.g., help with eating, bathing, dressing, and other services); approximately 800,000 persons now live in these facilities (National Center for Assisted Living, 2001). These facilities are overwhelmingly financed by private payments, although some participate in Medicaid. They are expensive, costing approximately $1,900 a month in 2000. Due to overbuilding, occupancy rates for assisted living are also relatively low.

Approximately 6,900 home health agencies participated in Medicare in 2003 (Centers for Medicare & Medicaid Service, undated). An unknown number of other home care agencies provide a range of skilled and unskilled services, including personal care, housekeeping, respite care, adult day care, nursing, and other services.

Both institutional and noninstitutional services face difficult problems of recruitment and retention, which will only get worse over time as the imbalance between long-term care demand and the supply of workers increases. These workforce problems are due to low wages and benefits, lack of training, the nature of the work, and the organizational culture (Stone and Wiener, 2001).

NON-VA LONG-TERM CARE FINANCING

Outside of the Department of Veterans' Affairs, the major sources of financing long-term care for older people and younger persons with disabilities are out-of-pocket payments, private insurance, Medicare, Medicaid, the Older Americans Act, and State-funded programs (table 1).

Table 1.—Long-Term Care Expenditures for Older People, by Source of Payment and Type of Service, 2004

[in billions of dollars]

Payment source	Institutional Care	Home Care	Total
.			
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private insurance	2.4	3.3	5.6
Out-of-pocket	35.7	8.3	44.0
Other	2.0	2.5	4.4
Total	92.4	42.5	134.9

Source: Congressional Budget Office, 2004.

• Out-of-pocket expenditures are a major source of financing for long-term care services. This is a consequence of the lack of either public or private insurance programs for long-term care that would otherwise cover the cost. Because services are expensive, they are a financial burden to most persons who use them. For example, the average private charge for a year in nursing home care was approximately $62,000 in 2002 (MetLife, 2004).

• Private long-term care insurance has been growing steadily since the mid-1980s but finances less than 5 percent of total long-term care expenditures. About 9 percent of the population age 55 or older has long-term care insurance, as does far less than 1µpercent of the younger population (Johnson and Uccello, 2005). A key barrier to the growth of private long-term care insurance is its high cost. For example, the average cost of a good quality policy bought at age 65 was $2,862 per year in 2002 (America's Health Insurance Plans, 2004). A variety of studies suggest that only about 10 to 20 percent of older people can afford private long-term care insurance, a proportion that will not change greatly over the next 20 years (Rivlin and Wiener, 1988; Wiener, Illston, and Hanley, 1994). Thus, private long-term care insurance is unlikely to be a major source of financing for long-term care.

• Medicare, the Federal health insurance program, provides nearly universal coverage for older people and some younger people with disabilities. Although primarily an acute care program (i.e., hospital and physician care), Medicare covers some nursing home and home health services, but generally of a short-term nature; long-term care is not covered. Specifically, Medicare covers skilled nursing facility services only when a beneficiary has spent 3 days in a hospital, is admitted to the nursing facility within 30 days of the hospitalization, and needs skilled nursing or rehabilitation services. Coverage is limited to 100 days, but the average length of Medicare-covered stay was only about 33 days in 2002 (Centers for Medicare & Medicaid Services, undated). The home health benefit is available to homebound beneficiaries who need intermittent or part-time skilled nursing or rehabilitation services. Although the home health benefit was evolving into a long-term care benefit during the early 1990s, the Balanced Budget Act of 1997 sharply reestablished the home health benefit as a skilled, short-term service. There is no coinsurance for home health; in 2005, there is a required co-payment of $114 a day for skilled nursing care after the 20th day in the facility.

• Medicaid is by far the dominant source of funding for long-term care services. It provides funding for persons who have low incomes or have been impoverished by the high costs of acute and long-term care. While the majority of Medicaid funds come from the Federal Government and there are some national requirements (especially for quality of care in nursing homes), States are responsible for administration and have substantial flexibility in determining eligibility and covered benefits.

Although nursing home and home health care are mandatory services and must be provided on an open-ended, entitlement basis, States vary greatly in their coverage of home and community-based services. Approximately 32 States and the District of Columbia cover personal care services as part of the regular Medicaid program (Burwell, Sredl, and Eiken, 2004). At their discretion, States may provide long-term care services under so-called home and community-based services waivers. Under waivers, States can provide a broad package of services that Medicaid does not routinely cover, and they can exert far greater fiscal control than they can under the regular Medicaid program. Unlike the rest of the Medicaid program, States can limit the number of waiver beneficiaries, and some States have waiting lists. Nonfinancial eligibility for waiver services is limited to persons who need nursing home care.

In all but a few States, the vast majority of Medicaid funds are spent on institutional care rather than noninstitutional services; nationally, in 2004, approximately 23 percent of Medicaid long-term care spending for older people was for home and community-based services (Congressional Budget Office, 2004). This is, however, a substantially higher percentage than in the Department of Veterans Affairs programs.

Financial eligibility standards for Medicaid are strict, complicated, and vary by State (Bruen, Wiener, and Thomas, 2003). Medicaid nursing home residents must contribute all of their income toward the cost of care, except for a small personal needs allowance of about $30 a month. Individuals may keep only $2,000 in nonhousing financial assets, although the home is generally an exempt asset in determining eligibility. However, States are supposed to recover the cost of Medicaid expenditures for long-term care from the estate of Medicaid beneficiaries, including the home. The community-based spouse of Medicaid nursing home residents may keep more of the couple's income and assets than is allowed single individuals.

Due to the high cost of long-term care services, a significant proportion of Medicaid beneficiaries in nursing homes "spend down" and are impoverished by the cost of nursing home care. Approximately two-thirds of nursing home residents have their care paid by the Medicaid program. Thus, Medicaid long-term care services provide a safety net for the middle class as well as for the poor.

Medicaid financial eligibility standards for persons in the community generally require beneficiaries to be eligible for the Federal Supplemental Security Income program, the cash welfare program for the aged, blind, and disabled. This program provides benefits at about two-thirds of the Federal poverty line and limits nonhousing assets to $2,000. A relatively few number of persons in the community "spend down" to Medicaid eligibility because of high medical care costs. Depending on State choices, persons receiving Medicaid services under home and community-based services waivers may have incomes up to 300 percent of the Supplemental Security Income level (about twice the Federal poverty level).

• Other Federally funded Government programs include home and community-based services financed through the Older Americans Act, the Rehabilitation Act, and the Social Services Block Grant. In addition, many States use their own funds to provide home and community-based services to persons who do not qualify for

Medicaid. In general, these Federal and State programs have financial eligibility levels that are slightly above Medicaid but are small in terms of total expenditures.

CONCLUSIONS

Several implications can be drawn for veterans (and the general population) from this review of long-term care services and financing:

- For both the veteran population and the general population, the demand for long-term care is certain to increase sharply over time. The United States does not have a coherent plan for dealing with the aging of the population.
- Overall, many current nursing homes have excess capacity that could absorb the reduced demand by Department of Veterans' Affairs-funded facilities. Whether the excess capacity and the reduced Department of Veterans Affairs capacity are in the same locations is unknown. Overall, the growth of long-term care services is likely to be impeded by a workforce shortage that will almost certainly grow dramatically worse over time.
- Although the supply of home and community-based services has been increasing, there is a stronger institutional bias in the Department of Veterans Affairs' programs than in the general community. However, the overall long-term care system has a strong institutional bias.
- Current financing for long-term care and acute care services is highly fragmented with multiple funding sources and a lack of integration between acute and long-term care services. While the extent to which Department of Veterans Affairs services achieve a high level of service integration is unknown, it provides a potential for integration that may be better than in the general community.
- Current financing of long-term care is dominated by public programs, and that is likely to remain so in the future. While private sector initiatives will play a larger role in the future, they are likely to remain a relatively small source of financing for long-term care.
- Medicaid is the dominant source of funding for long-term care. It is a strictly means-tested program. Initiatives to reduce Department of Veterans Affairs funding for long-term care will likely increase Medicaid expenditures, at least marginally, and are likely to be resisted by the States. This will occur at a time when States are still experiencing fiscal difficulties.

In conclusion, Americans have not yet begun a serious debate about the future of our aging society and the role of long-term care within it. The demand for long-term care will only grow dramatically over time, within both the veteran population and the general population. It is time to begin that debate.

Chairman CRAIG. Doctor, thank you. That is a great way of summing up this first panel. Before we go to 3-minute-question rounds of our colleagues, we have been joined by two additional colleagues and Members of this Committee, Senator Rockefeller and Senator Salazar.

Jay, do you have any opening comment you would like to make prior to the question round?

Senator ROCKEFELLER. Mr. Chairman, I passed you a little note in which I pointed out my day book was yesterday. I do have something I want to say, and I could say it from my soul or I could say it in a more disciplined fashion, which will happen in 2 minutes when my today's book arrives.

[Laughter.]

Chairman CRAIG. Well, we will allow you the choice. This is May 12th.

[Laughter.]

Chairman CRAIG [continuing]. 2005.

Senator ROCKEFELLER. Not to me.

Chairman CRAIG. Right. Senator Salazar. Ken.

OPENING STATEMENT OF HON. KEN SALAZAR, U.S. SENATOR FROM COLORADO

Senator SALAZAR. Thank you very much, Mr. Chairman, and Ranking Member Akaka. I very much look forward to the testi-

mony today and to grapple with the issue of long-term care. It seems to me that Dr. Wiener's statement on the need to have a coherent plan is something that we need to make sure that we work on out of this Committee and that the Veterans' Administration works with us on that issue. I very much look forward to the testimony and figuring out how we move forward together on dealing with this major challenge.

Thank you.

Chairman CRAIG. Ken, thank you. We have also been joined by our colleague——

Senator SALAZAR. Mr. Chairman, I do have a longer statement that I would submit for the record.

Chairman CRAIG. Fine. We will allow it to become part of the record. Thank you.

[The prepared statement of Senator Salazar follows:]

PREPARED STATEMENT OF HON. KEN SALAZAR, U.S. SENATOR FROM COLORADO

Thank you Chairman Craig and Senator Akaka for calling this important hearing.

It is a brave step because many in this administration would like to see the issue of VA long-term care swept under the rug.

The VA is already having a difficult time providing long-term care to veterans, and the administrations budget request would make the situation much much worse. It would literally decimate State nursing homes and force thousands of elderly veterans out in the cold.

As I was studying this issue, I was struck by the differences between what we are talking about here in Washington, and what is happening on the ground in Iraq today.

Earlier this week, members of 1st Platoon, Lima Company, of the Marines' 3rd Battalion, 25th Regiment were involved in a fierce firefight in Iraq about 15 miles east of the Syrian border. While sweeping for insurgents, the platoon was ambushed and one of their members was fatally injured. Rather than leaving their man behind, the Marines stayed. They fired grenades, artillery rounds, 500-pound bombs and a rocket at the enemy. They launched five separate assaults and lost another Marine in the process. They gave everything they had to complete their mission and not leave their comrade behind.

Our troops in Iraq are offering us that kind of bravery and dedication every day in Iraq. The least we can do for them is ensure that we will not leave them behind when they return home.

But that is exactly what we are doing. Our greatest generation of Americans is aging rapidly. These are the soldiers who refused to leave men behind at Normandy and Guadal canal. These are our fathers and grandfathers.

In 10 years, the number of vets who are 85 or older is expected to increase from approximately 870,000 to 1.3 million. Compare 1.3 million veterans to the 33,000 people the VA now cares for in all of its nursing home care. Right now, the VA is unable to care for a drop in the bucket. And the Administration is doing everything it can to reduce the VA's capacity to handle long-term care.

Today, we are going to hear very different perspectives on how the VA is faring and how the Administration's budget request would impact care.

Dr. Perlin, in his prepared remarks offers one perspective. He says that the VA is "meeting current demand and will meet all of the projected demand for nursing home care" within current capacity. Perlin says that the Administration's budget "goes beyond the requirements" of the 1998 Millennium Bill.

All the other witnesses will offer a dramatically different view. I agree vehemently with Ms. Alvarado-Ramos, Mr. Cowell and Mr. Mooney that this Administration's budget would be devastating for our veterans. I share their concerns about proposals to reduce per-diem payments, eliminate construction grants and eliminate minimum capacity requirements. I share their concern that the VA's commendable move toward expanding non-institutional care should not be a smokescreen for reducing desperately needed nursing home care.

By holding this hearing we will be shedding light on the real challenges we face. And I hope we will start to quantify what resources we need to ensure that no elderly veteran is left behind.

Chairman CRAIG. We have also been joined by our colleague John Thune. If you have any opening comments prior to the questioning round, we have just completed the testimony of this first panel.

Senator THUNE. Thank you, Mr. Chairman. I will wait till we get into questions, but I appreciate your rightly focusing on this very important issue and appreciate the panelists being here to provide insights.

Thank you.

Chairman CRAIG. Thank you.

Let me start. Dr. Perlin, it is my understanding that approximately 50 percent of VA's long-term care patients are cared for in beds provided by State veterans homes and that VA spends only 15 percent of its long-term care budget on this care. Why would VA find it advantageous to reduce expenditures to these homes when clearly they appear to provide the best bang for the buck in VA's long-term care program?

Dr. PERLIN. Well, Thank you, Mr. Chairman, for that question. First of all, I want to acknowledge a very positive and obviously longstanding relationship with the State veterans' homes. They are phenomenal partners and really create very positive environments for America's veterans.

The issue is not to necessarily reduce that relationship in any way. It is really a question of focus on the mission, core mission of serving those veterans with service-connected disabilities and being able to meet their needs. In fact, the State veterans' homes with a census this year to approach approximately 18,500, all but 922 are other than priority 1–A, or those individuals who are 70 percent or greater service-connected.

The relationship is tremendously important, though, because the State veterans' homes are a wonderful complement to VA's nursing facilities which provide care to those individuals who do have unique needs, who need post-hospital acute rehabilitation, who need help with spinal cord injury, ventilator dependence, mental illness, individuals who require a greater level of care and a skill set that is unique offered in VA. So it really comes down to a policy question of being able to meet the needs effectively for those individuals with service-connected disabilities as a key priority.

Chairman CRAIG. Is consistency among all programs truly worth sacrificing this, I think, tremendous low-cost, high-impact program?

Dr. PERLIN. I would plead the equity of access is tremendously important, but the State veterans' homes stand on their own merit. As mentioned, they are a wonderful adjunct in terms of providing care for veterans, environments that are of high quality, quality that we evaluate, and environments that have by definition the camaraderie of fellow service members.

Chairman CRAIG. Your testimony notes that VA has greatly expanded its non-institutional care program over the past several years, and I commend you all for that. However, it is my understanding that the level of non-institutional care services varies widely from network to network, and in some cases even hospital to hospital. For example, some facilities limit the number of days per year a veteran can receive adult day health care. Others allow unlimited days, but restrict total populations. Is there a more nationalized approach to service availability than I have just sug-

gested; or, if not, should there be one, and what do you believe are important considerations in developing such a policy?

Dr. PERLIN. Mr. Chairman, I do think it is fair to say that there has been and continues to be some inconsistency in availability of non-institutional care services across all of VA, across networks, even from hospital to hospital. That is changing and changing rapidly following the GAO report, which helped to identify the magnitude of some of this inconsistency. We have been working to invest heavily in increasing the non-institutional care services. In fact, for the year just completed, there has been almost 20 percent growth, and we are on a path of 18 percent increase in funding and capacity in non-institutional care such that all needs are consistently met for all veterans by 2011.

In the near term, though, to reduce some of the disparities, we are increasing those areas that do have the greatest limitations, and that is the primary focus.

Chairman CRAIG. OK. On the same note, GAO has pointed out that availability of different services—adult health care, home-based primary care, home respite—is inconsistent across differing regions of the United States.

First, has there been an improvement since GAO first leveled the criticism? And second, do you think there are some areas of the country, such as rural versus urban or east versus west, that will lag behind others in availability of non-institutional services; and if so, why?

Dr. PERLIN. To the first part of the question, sir, I think GAO was correct in terms of some of the inconsistency, and your comment whether there has been progress, the answer is absolutely. In fact, I was going to testify, on the basis of these notes, that we opened our 100th home-based primary care program—Dr. Burris told me this morning that the number is actually 102. That increase in home-based primary care is from 77 to 102 programs in less than the last 5 years.

As to your important question about access of services for rural veterans, this is one of the areas where we hope very much to work with this Committee in terms of using technologies based on our electronic health record and extending that information to the patient's home to allow support and monitoring and safe haven for patients when they may be geographically isolated from population centers or some of the inpatient facilities. So absolute focus in that area.

Chairman CRAIG. Thank you. My time is up.

Senator Akaka.

Senator AKAKA. Thank you very much, Mr. Chairman.

We seem to want to press for the identification of services. I would like to ask each of you this question: Which veterans should be ensured long-term care? Dr. Perlin.

Dr. PERLIN. Ranking Member Akaka, that is really, I think, the fundamental policy issue, is what can VA provide in terms of long-term care services. Every morning I walk into our building and the inscription that dictates our mission, to care for those who have borne the battle, dictates what we do as doctors, nurses, individuals who are not only caring about veterans, but passionate about veterans. Our instinct is to do as much as we can for everyone. But

the fact of the matter is that we have challenge right now despite the fact that actually there are two veterans for every veteran that the statute says we should be providing long-term care for, we go beyond that mission. And I think it is impossible that we can be all things to all people and continue to deliver accessible high-quality care to those who have borne the battle.

The statutes that authorize long-term care provide that care, priority 1–A, or those that are 70 percent service-connected or greater. And in 2004, our average daily census—which is more than people; it is the number of people in beds on any given day—was 23,965; 8,000 were priority 1–A. Sixteen thousand of that average daily census were other than priority 1–A, or 70 percent service-connected or greater. So even today, and certainly even with the President's or VA's proposed budget of providing care not only to priority 1–A, but also priority 1 through 3, that is all veterans with compensable service-connected disability and those individuals with special needs, such as spinal cord injury, serious mental illness, hospice, respite, and post-hospitalization care, we are well beyond that statutory mandate.

That said, we want to be humane and practical and contemporary in our approach. And Dr. Wiener's testimony identifies that we have traditionally an institutional bias and the movement to the community as to the least restrictive environment and home care. And we want to be pragmatic as well, practical, in making sure that we don't back up our acute care hospital by not having a place where patients can recover in a less acute environment. So it raises that fundamental policy question that you ask: Are we really saying that we are guaranteeing long-term care for all? If so, it is really beyond what we would be able to practically offer and it is beyond what veterans would request in the sense that they make this choice based on geography, having a loved one close by.

So regardless of outcome on this policy question that VA and this Committee are debating today, I think we have an obligation to clarify for veterans what it is that we will do so that they can plan accordingly.

Senator AKAKA. Thank you, Mr. Secretary.

Your thoughts, Ms. Ramos.

Ms. ALVARADO-RAMOS. In respect to the veterans who are in priority 1–A, as an example, the State Association of Veterans' Homes and our homes have gone on the record with the VA in that, as an alternative to care to veterans who are in those priorities that the VA has an obligation to provide long-term care, the State veterans home system is an absolutely more economical alternative and could save the VA significant amounts of dollars should those veterans be taken care of in our homes under those conditions.

Now, there have been issues because of the State homes program being left out of the language in the Mill Bill that addresses the issue of the 70 percenters, that we cannot enter into a contractual relationship with the VA to be able to provide such care. And this is outside of the per diem program. So there are opportunities for the VA to extend the reach of its dollar by continually looking at the State veterans' home system as a partner and as a viable alternative to be able to extend themselves and be able to provide more care to more veterans in those exact priorities.

Senator AKAKA. Dr. Wiener.

Mr. WIENER. I am not sure which group should get priority, but I think one thing is very clear. That is that the aging of the veterans population, the sort of self-selection into the VA by people with higher levels of disabilities, and the new levels of disabilities that we have by injuries being caused by the war in Iraq mean that the demand for long-term care is increasing and it is going to continue to increase. And I would urge the VA to try to increase its commitment to long-term care services rather than decrease it, because that is where the need is going to be. People with disabilities have high acute care costs, they have high long-term care costs, and that ought to be where the VA puts its focus.

Senator AKAKA. Thank you, Mr. Chairman. My time has expired.

Chairman CRAIG. Thank you. Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Dr. Perlin, you said in your statement that home-based care has increased at, I think, 11 percent and that it had maintained an incredible increase in comparison to everything else. Do you see that that percentage will continue, and will the differentiation between that and true long-term care, will that be maintained? Is that where you see the largest growth areas of percentage?

Dr. PERLIN. Senator, thank you very much for that question. We agree that the non-institutional growth will be maintained. It is actually 19 percent last year and in fact will be increasing 39 percent in budgeting between 2004 and 2006. So we intend to maintain and really push that.

The reason for that is, just as Dr. Wiener is suggesting, is that the needs increase. The question is how do we best meet those needs. We see that the needs are for some institutional care, we see that there are needs for different levels of institutional care, some care that is more generally supportive, some care that is intensely clinical and rehabilitative, some care that meets special needs—and some care that offers veterans, or any older American, the choice or the opportunity to remain in their community. And that individual, where in the past the default has been institutional care, it has been one-size-fits-all when that is really not what is needed. And for many of our World War II veterans, that population that is reaching that age of 85, the disruption that that singular choice would offer is not just to aging successfully in their community, it is disrupting a spousal relationship of even 60 years.

So it is an area that, as you indicate, we will continue to invest very aggressively in.

Senator BURR. The Chairman brought up the issue of geography and how that affects maybe the structure of things. North Carolina is the largest growing veterans population as a percentage in the country. Is the VA planning for the long-term care explosion that potentially will happen in a State like North Carolina that we can track today?

Dr. PERLIN. Absolutely. We recognize that North Carolina is one of the States that is growing at the fastest rates. And a lot of retirees are going there, so the issue has accelerated. In fact, Dr. Burris, Mr. Klein, who are with us here today, have done actuarial modeling, for the first time basing projections on actuarial data based on the number of veterans in a region, to being to project

and help us rationally identify where we need to put resources, be they non-institutional or institutional long-term care.

Senator BURR. Let me turn to Dr. Wiener for a second since we have the knowledge of not just a perspective on VA, but a perspective on long-term care, big picture.

As Medicare and Medicaid reimbursements are continuing to be cut, as they continue to be cut, clearly to meet the need of long-term care in the future there has to be capital that comes in and builds the infrastructure for individuals. When you have such a large proportion that is funded either by Medicaid, in the case of the State program, or Medicare, the services that come in for the acuity issue, what does that do to the capital for the future expansion of long-term care facilities in this country?

Mr. WIENER. Well, the access to capital will depend on how much reimbursement is cut and what kind of reimbursement systems States adopt. Clearly private sector, private insurance pays a higher rate than does Medicaid. But the history for the last 25 years has been a slowing increasing percentage of nursing homes that are Medicaid as the cost of nursing home care has gone up faster than incomes. So currently, about two-thirds of nursing home residents have their care paid for by Medicaid, about another 9 or 10 percent are paid for by Medicare. So it is three-quarters by public programs. And if you add in VA, it gets even higher.

So the access to capital is really going to depend very heavily on what happens to those public programs. As I said in my testimony, I expect private insurance to increase, but there is such a strong barrier because of affordability, unless there are extremely aggressive subsidies which are in themselves very expensive, I don't expect private long-term care insurance to be a major source of financing.

Senator BURR. Are we on a pace in America to be able to provide all the long-term care slots that you project we might need in the next decade, two decades?

Mr. WIENER. Well, that is really a decision largely to be made by the people here in this room and your colleagues. Because my projection is that at the height of the baby boom generation about 2.5 percent of the gross domestic product will be for long-term care for older people. That will be about 50–75 percent higher than it is now. Is that affordable? Well, that is up to you to decide. It is not, in my view, the end of civilization as we know it, but it certainly will be an additional burden that will exist whether we finance care publicly or privately.

Senator BURR. Thank you, Doctor.

Thank you, Mr. Chairman.

Chairman CRAIG. Thank you very much.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Wiener, I want to put my questions to you. The Under Secretary for Health has indicated that what we did back in 1999 to implement sort of outpatient long-term care, which had never been done before by the Government for any purpose at all, actually didn't get started, and he talked about it took a long time to start because there was resistance to it. He says it is going up by 19 per-

cent and will be 37 percent at some point. But that is from a base of virtually zero, from my observations.

Now, the question that Senator Burr asked, I think, is the main question: What is our state of mind for long-term care? And the state of mind for long-term care is that we have no long-term care policy at all. You either get it through Medicaid, which we are cutting, and those cuts last over 10 years, they will keep accumulating, getting worse. In West Virginia, and I am sure in your State too, virtually all of our budget problems are involved either with public employees health insurance, which is separate but basically Medicaid, and we are having to cut, I think, $165 million out of our Medicaid budget this year.

So we are building a State nursing home. And I can really foresee a situation where it will open and there won't be many people there to take care of anybody. I mean, we did a—in the late 1980s, do you remember the Pepper Commission?

Mr. WIENER. I certainly do, sir.

Senator ROCKEFELLER. Well, it ought to be a bible. Because we passed—and this was during the Reagan Administration, a preponderance of Republicans on the committee, I was chairing it—we passed 11–4 a national long-term care policy. Assets, all of those things taken into account. But to me, the greatest dilemma—I mean, I think ever since the Clinton health care effort failed, we have walked away from health care in this country. We have done it for veterans. Veterans, it is tragic to say, but it is somewhat easier to do it for veterans because people don't pay as much attention to them as we ought to.

But there isn't really—I mean, for example, long-term care involves Alzheimer's, it involves all kinds of mental health. I don't think that you could answer me that you are doing anything about Alzheimer's.

Dr. PERLIN. Do you want to talk about the Alzheimer's?

I asked Dr. Burris to talk about some of the Alzheimer's programs, both in terms of research——

Senator ROCKEFELLER. But I asked you. You are in charge.

Dr. PERLIN. I would be happy to. In fact, we have Alzheimer's programs as a unit. In fact, a large part of our research portfolio, which I am pleased to say is about $1.651 billion——

Senator ROCKEFELLER. Well, you are talking too fast. You got into polio?

Dr. PERLIN. Our—no, our research portfolio——

Senator ROCKEFELLER. Oh, portfolio.

Dr. PERLIN [continuing]. Includes a great deal of attention to issues that are really related to aging. Because, as has been noted, as this discussion identifies, the challenges the veterans face are not dissimilar from the challenges that America faces in terms of diseases of later years.

Senator ROCKEFELLER. Are you telling me you are doing research on it or are you——

Dr. PERLIN. We have both——

Senator ROCKEFELLER. I am not aware of any services you are providing for Alzheimer's or mental health.

Dr. PERLIN. For Alzheimer's or mental health? Sir, we have approximately $2.2 billion in specialized mental health services, $3

billion, including pharmaceuticals for mental health, and $10 billion——

Senator ROCKEFELLER. Under long-term care?

Dr. PERLIN. No, not under long-term care, under long-term——

Senator ROCKEFELLER. That is what I am talking about, long-term care.

DR. PERLIN. Under long-term care, sir, we have specific programs in Alzheimer's and for veterans with cognitive decline, and the geriatrics evaluations and management programs, the GRECs, the Geriatric Research, Education, and Clinical Centers, of which there are a number, and these programs are pervasive throughout the entire country.

Senator ROCKEFELLER. Well, you have either done an incredible job in 3 months or you fooled me entirely.

Dr. Wiener, how would you react to that?

Mr. WIENER. Well, the VA has—I mean, you can't really separate long-term care from Alzheimer's disease. I mean, half of the people in nursing homes nationally have some kind of cognitive impairment most likely due to Alzheimer's disease. So I think a lot of long-term care is treatment for people with Alzheimer's disease. I can't speak specifically on programs within the VA that address Alzheimer's disease.

Senator ROCKEFELLER. But the Under Secretary has talked about "pervasive programs" for Alzheimer's and long-term care. That comes as news to me. Do you have any view on that? You are the third party looking in here.

Mr. WIENER. Well, as I said, long-term care and Alzheimer's disease are not very separable. If you are providing long-term care services, you are probably providing services to people with Alzheimer's disease.

Senator ROCKEFELLER. Yeah, but don't—we need to stop there, because Alzheimer's requires specialized nursing. Am I right?

Mr. WIENER. Well, there are many issues related to Alzheimer's disease that are separate from people with just pure physical disabilities, but again, half of the people in nursing homes nationally have some kind of cognitive impairment and probably have Alzheimer's disease. And they are not receiving specialized treatment.

Senator ROCKEFELLER. Well, Mr. Chairman, I am not sure where I got on that, but my—I would just say to you my concern is that this Nation is resolutely—and, you know, because it is endlessly expensive. And endlessly endless, long-term care. It is the great need that we have not met, we will not face. As I say, some of us got this done in 1999 for the Veterans' Administration and for years they just kind of pushed it aside. And now they have done some things and, according to the Under Secretary, it is pervasive. I can't really make out what Dr. Wiener is trying to tell me on this. But put this member down as very skeptical, very concerned, and very worried.

Thank you.

Chairman CRAIG. Thank you.

Ms. ALVARADO-RAMOS. Mr. Chairman, may I please address that issue for a second?

Chairman CRAIG. Certainly.

Ms. ALVARADO-RAMOS. Because, at least in my experience within Washington State, I am working with VISN 20, I must say that the geriatrics program has assisted our facility significantly when it comes to the issue of mental health and when it comes to the issues of Alzheimer's and some training from the VA staff with our staff. I cannot speak entirely for the rest of the Nation because I don't know what the rest of that experience is, you know, but the GREC program that the VA has, in the State of Washington particularly, is exceptional.

Chairman CRAIG. Thank you for that comment. I can understand the frustration that the Senator has. I think we have an intern geriatrics program at the center in Idaho also, where University of Washington students study, and there is a great emphasis now being placed. It is a growing new emphasis, but it is not unlike that of the non-VA facilities and non-VA services. How much money have we put into Alzheimer's research here in the last 5 years? A good deal more than we did 5 years prior. And I agree with you, though, we are just touching the edge of it and the kind of work that needs to go on to understand it or even to resolve the issue.

So Senator Salazar. Ken.

Senator SALAZAR. Thank you, Mr. Chairman.

Dr. Perlin, I have a question of you, and that is I would like you to think and describe to us what would be your coherent plan for long-term care. I hear Dr. Wiener talking about how he doesn't think that we have a coherent plan for dealing with the aging population, and that would include our aging veterans' population. I would like you to comment on it in this particular context.

And let me also say, I think when you hear the questions from me or Senator Rockefeller or any other Members of this Committee, it is because we care, we confirmed you with, I think, a unanimous vote and it is because we have great faith in your interest and passion for these issues. But at the same time, it seems to me that what we really need to know is where the plan is for the Veterans' Administration with respect to these critical issues for veterans, and we need to know what we ought to be doing on the one plane and then the reality that we have to deal with on the budget plane on the other hand.

For example, in my own State, with the State veterans' nursing homes that were on the chopping block in the President's budget and the VA's budget, we would have had—in the little town of Walsonburg—93 out of 100 residents in a State veterans' nursing home would have basically been kicked out because the budget wouldn't have been there to continue the funding for that nursing home. Because of the action of Senator Craig and others on this Committee, we were able to restore the funding. But to me, what was happening there in Walsonburg did not symbolize or speak to me about coherency within the plan of the VA with respect to long-term care. It seems to me that that decision was really being driven by budget realities and budget cuts that you were facing.

So I would like you to step back and tell me and tell this Committee what you would see as the coherent plan with respect to dealing with long-term care for veterans.

Dr. PERLIN. Thank you, Senator, for the question and thank you, and Senator Rockefeller, as well, for your passion and advocacy for long-term care for veterans and the advocacy for mental health care, the advocacy of this Committee. I take the questions as an expression of that absolute passion and dedication. I appreciate through your vote of confirmation that is seen as a passion that is central to why we are in VA to begin with.

The view for a coherent system, what would it look like? It would be a system where on the—of those individuals with cognitive disability, like Alzheimer's disease, particularly if it were very advanced—where we have specialized services to meet those needs; where we have, on the side of intense care, facilities for individuals who do have those special needs, like spinal cord injury, like ventilator dependence. It would have a system that complemented acute hospital care and provided rehabilitation for the individual who is going to get back to function with some restorative care—the individual after a stroke, the individual after a hip replacement. It would have components that are available as well for patients who don't have a very positive trajectory in terms of longevity, but for patients whose health is going to deteriorate, to have the hospice, the palliative care to make veterans as comfortable as possible. It would have the expression particularly of these features not only in the institution, but in the home. So, particularly for the veteran who has reached the end of his or her life and is dying, if their choice is and they can be supported effectively in the embrace of their family, that we can do that.

It would then be complemented by a level of care that would be supportive and having good maintenance for those individuals who aren't so needing of clinical service that they have to be in an almost hospital-like environment, but an environment that resembles what in the broader health care environment are being described as greenhouses, environments that are very homelike, where individuals with some mental limitation or some physical limitation can live as normal and as functional a life in as residential a setting as possible.

And then the other final component of that is for those individuals who really don't need that level of support, who want to maintain the social-spousal-community relationship. It could be supported through technology or assistance in their home with home health and that sort of thing. In fact, we have gone from about 19,800 census in 1998 to about 36,000 as of the beginning of 2005, veterans being supported in that way. So I see it as all of those different elements.

Senator SALAZAR. Let me ask you, if I may, Dr. Perlin, with respect to that vision, which I find commendable in the components of that plan, has the VA looked at the cost factors associated with that plan, and would you be prepared to provide that information to this Committee?

Dr. PERLIN. Yes. I think we could take a breakout of what different elements cost and be able to provide that information to you. I think' in our proposal, we provided an articulation of, really, what that vision provides if care were provided to priority groups 1 through 3, those individuals with special needs and those individuals who need recovery after a hospitalization.

Senator SALAZAR. Mr. Chairman, I know my time is up, but it seems to me that it would be very useful for our Committee to have the components of the plan that Dr. Perlin articulated looking long-term, but also with respect to each of those components, to have some cost figures associated with those projections. At the end of the day, the decisions that we are making here, the decisions that the VA and the President make on the budget, really drives what kinds of services we are going to be able to provide, whether it is the patients with Alzheimer's or other veterans that fall into any one of the categories that you describe. And I think it would be important for us to know if we were able to implement the coherent plan that you articulated, what are the costs associated with that and also what are the current gaps between what we are funding and what it would take to be able to effectively implement that plan.

I think that would be, at least for me personally, Mr. Chairman, it would be something that I would find very useful.

Chairman CRAIG. Well, thank you. I think that is a very valuable suggestion.

I have several more questions that I would like to ask. Senator Thune has stepped out for a moment. We will get to him when he comes back.

Ms. Ramos, let me go to you. Last year Congress passed Public Law 108–422, which made clear that per diem payments from VA for the care of veterans in State homes were not to be considered a third-party offset to Medicaid payments. Has the change had an intended effect on the offset that was occurring in homes throughout many States?

Ms. ALVARADO-RAMOS. There hasn't been very much change as far as additional States taking advantage of that particular law. We have about 19 States that do have Medicaid as one of its components to be able to defray the cost of long-term care in our facilities, Washington State being one of them. But the fact is that the addition of the Medicaid system into a home places a significant administrative burden upon the facility because there is already a VA system, inspection system rules and requirements, so therefore States, unless they absolutely have to, they are not going to go into the Medicaid system even though the law made available the opportunity for the per diem not to be offset.

Chairman CRAIG. Is there any concern that this change will force many States that have not been Medicaid providers to adopt a Medicaid standard because the fiscal incentive is too great?

Ms. ALVARADO-RAMOS. There are some States that are considering it, and I foresee that some will become Medicaid in the future. As you know, though, Medicaid funding has been reduced and likely is going to continue to be reduced, and those bring a very significant issue when it comes to veterans who presently are being cared for in our homes being placed into the Medicaid system, because right now they are overburdened. So for States to be able to take care of this additional burden that traditionally has been cared for by the per diem and the State contribution and the resident contribution, it would require for Medicaid to add additional dollars to be able to take care of this new population to the community nursing home.

Chairman CRAIG. Thank you.

Dr. Wiener, you have stated that only 10 to 20 percent of older people can afford long-term care insurance and that long-term care insurance is unlikely to be a major source of financing for long-term care. However, as the market for long-term care insurance grows, it becomes—or it should become—more affordable. It seems that one of the keys to affordability is to increase the number of younger people who make this investment, and Congress is nibbling around the edges of how you might incentivize that. Should we explore ways to increase the number of younger veterans who purchase long-term care insurance?

Mr. WIENER. Well, purchase of long-term care insurance at younger ages is clearly cheaper than at older ages, but it still can be a substantial amount of money. A good-quality policy bought at age 50 is still around $1,000 to $1,500 a year and is basically for a population that is concerned with other things—their general retirement, mortgage payments, saving for their general retirement, paying for college education for their kids. And so part of the dilemma for private long-term care insurance is that the age where it is more affordable you are not all that interested in it, but at the ages when you are older, when you are more interested because you see the risk, it becomes unaffordable.

So private long-term care insurance faces that kind of dilemma. My own research suggests that if people bought it at younger ages, for a much higher percentage of the population it would be affordable. But I have also done analyses that have looked at the effects of tax incentives, and in general, unless they are extraordinarily large, my research shows that they have a relatively small impact on the number of people who buy policies. But it costs a substantial amount of money, because everyone who would have bought a policy without the incentive would get the tax savings.

Chairman CRAIG. Do you have any published information of your research in those areas?

Mr. WIENER. Yes, I would be happy to submit that for the record.

Chairman CRAIG. I wish you would. I find it fascinating, and I think all of us are extremely concerned about this issue. The question is how do you get America to move in that direction. Obviously, it is affordability. And at the same time, it sounds like incentivizing doesn't always work that well in this situation.

Mr. WIENER. That is correct, sir.

Chairman CRAIG. Thank you very much.

[Witness failed to provide requested publication for the record.]

Senator Burr, do you have any further questions? Senator Rockefeller?

Senator ROCKEFELLER. Mr. Chairman, I always appreciate the way you phrase questions and probe. It is always very balanced and fair. I try to praise you every meeting I come to.

[Laughter.]

Chairman CRAIG. That is why I like you to attend. Thank you.

Senator ROCKEFELLER. But, you know, I run out of things that I can say after awhile.

Chairman CRAIG. I will give you some.

Senator ROCKEFELLER. No, you don't need to. You are just very, very good.

Let me go at this in a little bit different way, Dr. Perlin. A number of years ago we had a hearing on this committee about mental health. And I asked the VA to tell me how much it would cost to do mental health the right way, whatever that would mean, for all veterans. And then it took about 2 years for the VA to tell me at another hearing, OMB won't let us give you a number.

Now, we all know this is what we are talking about. And I am not saying there is anything you can do about that because that is the way Government is set up—you come in, you think you are going to run something, and then you are told what you can do and it is frustrating for you and you do the best you can. I know that.

But this is a little about what Senator Salazar was talking about, is the cost, what is the cost of long-term care. Is it not true, for example, that in the CARES Commission, in the body of it, that there really is no long-term care strategy being addressed in that CARES Commission? I believe that is true.

Dr. PERLIN. When the CARES Commission draft report first came out for review, the actuarial modeling had not been completed. That is, if not completed, nearing completion at this moment and, as I mentioned, based on actuarial. So technically it didn't have the benefit of all the information. It does now.

Senator ROCKEFELLER. And so what is happening now?

Dr. PERLIN. Well, exactly. That actuarial information is what we will use to look at the demographics, the veterans, the aging populations, large-growth States like North Carolina, and try to come to, you know, a rational approach to meeting all the veterans' needs, from those with very substantial, intense health care needs, to those that just need more modest support, and align the resources with the need.

Senator ROCKEFELLER. OK. If the per diem for State veterans' homes is being cut—and I forget what the figure is; it is $283 million or something of that sort in this year's budget, the per diem match. And this gets back to the whole question of how whatever it is—I mean, you say that everything is wonderful in the State of Washington.

Ms. ALVARADO-RAMOS. Just when it came to the issue of this mental health-specific issue that you asked about, sir.

Senator ROCKEFELLER. OK, but is this going to affect you?

Ms. ALVARADO-RAMOS. The per diem? Absolutely.

Senator ROCKEFELLER. Medicaid cuts?

Ms. ALVARADO-RAMOS. And the Medicaid cuts. Everything affects our home operations, but specifically when it comes to the long-term policy proposed, you know, in prioritizing, 80 percent of our residents would be ineligible for per diem and therefore we would have to find some other ways of placement.

Senator ROCKEFELLER. There we go. The point I was not making well.

Ms. ALVARADO-RAMOS. And the 80 that falls out are probably the poorest and most needy and medically compromised residents who may not be service-connected, yet they require 24-hour nursing home care.

Senator ROCKEFELLER. Which is—and now you have made another point for me, and that is that the service-connected factor runs for a substantial—for millions of American veterans, into po-

tentially lack of coverage for long-term care, mental health, Alzheimer's, et cetera. When I say "Alzheimer's," I am not just talking about Alzheimer's. I am talking about the whole range of diseases that are like that.

Ms. ALVARADO-RAMOS. Dementias.

Senator ROCKEFELLER. Yes. Yes.

So in my final 3 seconds, what are we going to do, Dr. Perlin, about this per diem crisis and the 80 percent factor?

Dr. PERLIN. Well, I think we have received and appreciate the views of this Committee. This Committee has spoken in a bipartisan fashion. Chairman Craig and Ranking Member Akaka have identified that this Committee does not support that proposal. So we hear that message.

Senator ROCKEFELLER. Thank you.

Chairman CRAIG. One last question of Dr. Wiener. It deals with nursing home populations. And you talked about the availability of nursing home beds today. Let me give you these figures and then ask you the question.

In my home State of Idaho, capacity is slightly lower than the national average. However, it continues to increase at a very significant rate. For example, 75 percent capacity, 2003; 79 percent capacity, 2004; today it is at 83 percent. The data suggest that occupancy rates may be increasing due to the fact that every year a few facilities reduce their numbers of licensed beds.

Is this the national trend? If so, would nursing homes still be available to absorb the veterans that would no longer qualify for care at VA-funded facilities? What are the trend lines on those bed availabilities?

Mr. WIENER. Well, I have been involved with long-term care for 30 years, and for the vast majority of that time nursing home occupancy rates have nationally been in the very high 80s or low 90s, and in a number of States it has been 95, 96 percent. And what is sort of historically unique is that in recent years occupancy rates have been falling and in general the level of nursing home residents has stayed, nationally, remarkably stable over the last 5 years or so. So as you noted, occupancy rates are partly a function of how many beds you make available, and you can——

Chairman CRAIG. That is true.

Mr. WIENER [continuing]. Increase your occupancy rate just by reducing the number of beds you make available. But in general, occupancy rates have fallen somewhat in recent years. Obviously, in some States, and your State may be an exception, but in general occupancy rates have fallen. So there are empty beds available. Whether they happen to be in the locations where State homes would be, whether they serve the same kinds of residents, whether the finances would match up, I certainly couldn't say. But there are substantial numbers of empty beds for nursing homes in this country.

Chairman CRAIG. Well, thank you all very much for your time with us. As we stated at the beginning of this hearing, this is an open discussion that will go on as we increase our awareness of the situation of long-term care for veterans and as we look at other areas for the other aging populations of our country. So this is a work in progress, and we thank you very much for your time.

Let me ask our second panelists, then, to come forward.

Our second panel is made up of Fred Cowell, Associate Director for Health Policy, Paralyzed Veterans of America; and Mr. Donald Mooney, Assistant Director for the American Legion.

So Fred, we will let you lead off. Thank you for being here.

STATEMENT OF FRED COWELL, ASSOCIATE DIRECTOR, HEALTH ANALYSIS, PARALYZED VETERANS OF AMERICA

Mr. COWELL. Thank you, Mr. Chairman.

Mr. Chairman and Members of the Committee, my name is Fred Cowell of the Paralyzed Veterans of America. PVA is pleased to offer its views concerning access to and the availability of long-term care services for America's veterans.

Mr. Chairman, three serious proposals are currently merging together that have the potential to seriously reduce VA's capacity to provide nursing home care to aging veterans. First, VA's fiscal year 2006 budget would reduce funding for VA nursing home programs by approximately $450 million and force VA to reduce its average daily census by about 4,000 patients. Second, VA is requesting Congress to repeal the nursing Home capacity mandate contained in the Veterans Millennium Health Care and Benefits Act. And third, the Administration's 2006 budget proposal would place a moratorium on grants for new construction and reduce the per diem rate VA pays to State veterans' homes for the care of aging veterans.

Mr. Chairman, these three proposals come at a time when America's aging veterans population is projected to significantly increase over the next decade. The General Accounting Office has projected the number of veterans age 85 and over will increase from 870,000 to 1.3 million over the next decade. This group of aged veterans will have a very significant demand for VA nursing home care services. Taken together, these three issues have a potential to create VA's long-term care perfect storm. If passed, these proposals will have negative consequences for aging veterans well into the 21st century.

Regarding eligibility, PVA supports the budget proposal to extend long-term care eligibility to veterans with catastrophic disabilities. Today, aging veterans with spinal cord injury or disease are at a serious disadvantage when it comes to the availability of specialized VA nursing home care. Currently, VA operates only four designated spinal care injury long-term care nursing home facilities, and none of these are located west of the Mississippi River. And taken together, these 4 facilities only provide 154 available beds, and of those only 115.6 were actually staffed in March of this year.

VA's CARES initiative has proposed to increase its designated spinal cord injury nursing home capacity by 100 beds. But only 30 of these beds will be on the West Coast. The addition of 100 beds is a step in the right direction, but these improvements are not yet a reality, and funds are needed for their activation.

For veterans with catastrophic disabilities, care in VA nursing homes is often their only hope. VA has the expertise to provide quality care to these veterans. Community nursing homes simply don't have the expertise or want patients with high acuity needs.

Veterans with spinal cord injury are often denied care in these private sector facilities.

Mr. Chairman, VA needs to maintain and expand its capacity to provide nursing home care for catastrophically disabled veterans.

On State veterans' homes, since 1998, State veterans homes have been handling a larger and larger share of VA's nursing home care workload. Currently, 50 percent of VA's nursing home care workload is provided in State veterans homes. PVA believes that these State veterans' homes are a valuable asset and should be protected. In addition to providing quality care, State veterans homes are a good value for VA. The GAO has said VA pays about one-third the cost of care when it refers patients to State veterans homes.

Mr. Chairman and Members of the Committee, PVA calls upon Congress to chart a course for VA nursing homes that avoids the pending storm. We request that VA's budget proposal to cut its nursing home program be denied. We ask you to approve long-term care eligibility for veterans with catastrophic disabilities. We ask Congress to maintain the nursing home capacity mandate contained in the Mill Bill. And finally, we request that State veterans homes be spared cuts in construction and per diem funding.

Mr. Chairman, that concludes my remarks and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Cowell follows:]

PREPARED STATEMENT OF FRED COWELL, ASSOCIATE DIRECTOR, HEALTH ANALYSIS, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, The Paralyzed Veterans of America (PVA) is pleased to present its views concerning access to, and the availability of, long-term care services for our Nation's veterans. My testimony also contains analysis provided by the veterans' service organization, authors of The Independent Budget for fiscal year 2006.

The focus of the testimony first looks at board, long-term issues affecting all veterans. Second, the testimony addresses the unique long-term care situation of veterans with spinal cord injury or dysfunction.

The fiscal year 2006 VA budget has proposed to restructure Veterans Health Administration (VHA) institutional long-term care services. The most significant impact of the proposed change is to shift the burden of long-term maintenance care for certain veterans whose conditions do not make them candidates for rehabilitation, to other payers, and eventually to Medicaid, the single biggest U.S. payer for nursing home care. The veterans primarily affected by this proposed policy would be those without compensable service-connected disabilities and who have no rehabilitation potential. The VA has indicated an intention to increase other long-term care programs such as palliative, hospice, respite, home-based primary and adult day care. The two changes, shifting maintenance care elsewhere, and increasing other programs, would produce $209 million in net savings in fiscal year 2006 and reduce VA's average daily census in VA nursing homes by about 4,000 patients.

According to VHA estimates the system—in-house, contract, and State beds combined—has 35,878 beds today. Based on actuarial projections and assuming continuation of current policy, VA will need 45,445 beds in 2013 and 43,042 beds in 2023 (95 percent occupancy rate). Under its proposed change in policy, VA's 2013 need will be 22,228 beds and 23,245 beds in 2023 (VA Office of Strategic Initiatives, March 2005). Thus, VA' s proposed change in policy will save funds and reduce VA's need to maintain beds while the patients who would have occupied these beds are shifted to other VA programs and to another Federal payer, primarily Medicaid.

This proposal comes during a time when the President has proposed to reduce the growth of Medicaid spending. The National Governors Association has reported that Medicaid programs nationwide are in financial crisis. Adding an additional burden to Medicaid at a time of crisis in that program is not well considered, especially given VA's expertise, quality and proven cost-effectiveness in providing care to enrolled veterans.

The veterans' service organization community is unclear on whether this proposed shift in policy is well considered by the Administration. Every report VA has issued on long-term care for the past two decades and more demonstrated that the oldest veterans among us, those from World War II and the Korean War, will present massive needs for long-term care near the end of life. VA leads the Nation in the study of aging, the establishment of clinical approaches, research, education and new treatment models to deal with diseases of old age. VA has established 130 VA nursing home care units, and has aided the States in establishing and sustaining 128 State homes for the long-term care of elderly veterans. As we begin to reach that pinnacle moment when veterans from the Greatest Generation begin calling on the VA system to address their end-of-life needs, VA is proposing to shift the burden and move into a type of niche market where it provides care to only that subset physically amenable to rehabilitation.

The VA's Capital Asset Realignment for Enhanced Services (CARES) process was designed and executed to review out-year needs for VA capital investments based on the study of health care markets nationwide. Phases I and II of the CARES process are complete; yet, VA was not able to make any decisions with respect to its capital needs for long-term or mental health care programs because its projection models were seen as insufficient to the task of clearly demarcating or confidently predicting those requirements for the future. We seriously question whether a policy proposal with such profound effects as the one VA has made in its budget should go forward before VA has clearly reviewed its capital asset planning needs in the long-term care arena. We say no.

GAO has reviewed VA's long-term care programs on a number of occasions. On May 22, 2003, GAO testified before the House Veterans' Affairs Committee concerning its review of non-institutional long term care programs. GAO found a high variation in availability of six VA programs: respite, home-based primary care, geriatric evaluation, adult day care, homemaker/home health aide services and skilled home health care. VA claims to have increased these and similar programs by 25 percent since this review was completed, and proposes to increase them by 18 percent more in fiscal year 2006. Until it can be verified that these non-institutional programs are increased and functioning at a level of satisfaction to veterans who would need these services, it seems an unwise decision to close institutional care beds that presumably are needed by these patients who cannot now avail themselves of home-based and other alternatives. Also, given the personal circumstances and social conditions of many veterans who enroll in VA health care, there may be no permanent residence in which to introduce alternative care programs for some.

We are also concerned about the status of VA's partnership with State homes. This historic relationship provides a superb example of a Federal-State partnership in long-term care burden sharing. The State home program has grown under both Republican and Democratic Administrations, and has carried strong bipartisan support by the Congress. VA's policy proposals would extend to the State homes as well, severely restricting the number of veterans placed in State homes and reducing payments to them by $293 million in fiscal year 2006. We are unsure why VA would want to remove a placement resource that has worked well in the past for tens of thousands of veterans who need long-term residential placement but could not be accommodated in VA beds.

Despite an aging veteran population and Congressional passage of Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act" (Mill Bill) VA has continuously, failed to maintain its 1998 VA nursing home required average daily census (ADC) mandate of 13,391. VA's average daily census (ADC) for VA nursing homes has continued to decline since 1998 and is projected to decrease to a new low of 9,795 in fiscal year 2006. VA is serving fewer and fewer veterans in its nursing home care program despite the minimum 1998 level set by Congress.

Now, VA is asking Congress to eliminate the mandatory ADC requirement contained in the "Mill Bill." This request by VA is not driven by current or future veteran nursing home care demand. In fact, the General Accounting Office (GAO) reported "the numbers of aging veterans is increasing rapidly, and those who are 85 years old and older, who have increased need for nursing home care, are expected to increase from approximately 870,000 to 1.3 million over the next decade."

PVA strongly feels that the repeal of the capacity mandate will adversely affect veterans and is a step toward allowing VA to reduce its current nursing home capacity. This is not the time for reducing VA nursing home capacity with increased veteran demand looming on the near horizon.

PVA is pleased to see an extension of eligibility for VA nursing home care that covers veterans with catastrophic disabilities contained in the Administration's 2006 VA budget proposal. In the past, VA has done a good job of recognizing the complex nursing home care needs of veterans with spinal cord dysfunction SCD) and has

provided care as resources were available. Providing eligibility to VA nursing home care for catastrophically disabled veterans will greatly improve VA access to these services for veterans who desperately need them and who have great difficulty in being admitted to private sector community nursing homes.

Mr. Chairman, there are unique advantages of VA nursing home care as compared to private sector care. Because VA nursing homes are most often co-located with a VA medical center they offer prompt access to VA acute medical treatment for elderly veterans. When veterans living in VA nursing homes require acute medical treatment their care is easily facilitated and efficiently coordinated between VA providers. Also, VA nursing homes provide a higher quality of care that that provided in private sector facilities. Patient surveys indicate that VA care is superior to the care provided in community nursing homes. VA and Congress must do everything in their power to maintain VA nursing homes as a valuable Federal asset.

For veterans with catastrophic disabilities, care in VA nursing homes is often their only hope. Community nursing homes simply don't want patients with high acuity requirements. Veterans with spinal cord injury are often denied care in these private sector facilities. VA must maintain and expand its capacity to provide nursing home care for catastrophically disabled veterans.

Mr. Chairman, thousands of veterans with spinal cord injury or a disease of the spinal cord (SCD) are at a serious disadvantage when it comes to the availability of specialized VA long-term (nursing home) care in their geographical area. Currently, VA operates only four designated spinal cord injury nursing home care facilities. These facilities are located at: Castle Point, New York; Brockton, Massachusetts; Hampton, Virginia; and the VA residential care facility at the Hines VAMC in Chicago, Illinois. As of March 2005, all of these facilities taken together only provide a total of 154 available beds and of those only 115.6 are actually staffed beds. As you can see the number of available nursing home care beds for these catastrophically disabled veterans is extremely low and none of these facilities are located west of the Mississippi River. Veterans with SCD who live west of the Mississippi River have no access to these specialized long-term care services unless they are willing to go on waiting lists, and leave their families and their home communities.

While VA's Capital Asset Realignment for Enhanced Services (CARES) initiative has proposed to increase VA's capacity for SCD long-term nursing home care by adding 100 additional beds at four locations (30 beds at Tampa, Florida; 20 beds at Cleveland, Ohio; 20 beds at Memphis, Tennessee; and 30 beds at Long Beach, California) much work remains to be done. And, as you can see, only one of these proposals will add new VA nursing home beds on the west coast. Additional specialized VA nursing home care capacity is severely needed especially in the western portion of the country.

A shortage in specialized SCD VA nursing home capacity is already a problem because of waiting lists for care and future demand for services. For example, the CARES long-term care projections (revised December 2004) for spinal cord injury indicate a VA gap in the number of VA available and designated beds versus the number of VA projected beds. VA's spinal cord injury long-term care data says, VA will require 705 long-term care beds in 2012 and 1,358 in 2022. While the 100 beds recommended and proposed in CARES is a step in the right direction these improvements are not yet a reality and funds are needed for their activation.

In conclusion, three long-term care proposals are merging together, simultaneously, that would contribute to a serious loss of capacity for veterans who need long-term care. First, VA's 2006 budget proposal would reduce the funding for VA nursing home care programs by approximately one half billion dollars. Second, VA's request to repeal the nursing home capacity mandate contained in the "Mill Bill" opens the door for VA to further reduce its nursing home capacity. Third, the Administration's Budget contains a proposal that would place a moratorium on grants for new construction and reduce the per-diem rate VA pays to State Veteran's Homes.

These three effects come at a time when America's aging veteran population will significantly increase over the next decade. Taken together these three issues create the conditions necessary for "VA's Long-Term Care Perfect Storm." This Perfect Storm will have negative consequences for aging veterans by reducing VA's nursing home capacity and damaging State Veterans' Homes, at a time of increasing demand, well into the 21st century.

Mr. Chairman, and Members of the Committee, PVA calls upon you to chart a course for VA's long-term care programs that avoids this pending storm. We request that VA's budget proposal to cut its institutional long-term care programs be denied. We ask Congress to maintain the ADC capacity mandate in the "Mill Bill." And fi-

nally, we request that the State Veterans Homes be spared cuts in construction and per-diem funding.

Thank you for this opportunity to present our views and concerns.

Chairman CRAIG. Fred, thank you very much.

Donald, welcome before the Committee. Please proceed.

STATEMENT OF DONALD L. MOONEY, ASSISTANT DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. MOONEY. Mr. Chairman and Members of the Committee, thank you for this opportunity to express the American Legion's view of current legislative proposals concerning the Department of Veterans' Affairs long-term care programs.

The American Legion is disturbed by VA's continuing efforts to limit its responsibility to America's aging veterans. This year's VA budget contains three legislative proposals that would further those efforts. The President's fiscal year 2006 VA budget request would repeal the provision of the Millennium Act requiring VA to maintain its nursing home care unit bed capacity at the 1998 level of 13,391. This black-letter law is referred to in VA's budget request as a baseline for comparison and in this capacity has significantly eroded rather than been maintained. VA had 12,239 beds in 2003 and 12,245 in 2004. The President's budget request only projects 9,975 in fiscal year 2006, a 27 percent decrease from the Millennium Act mandate.

The American Legion believes that VA should comply with the intent of Congress to maintain adequate nursing home capacity for those disabled veterans who are the most resource-intensive groups—clinically complex, special care, extensive care, and special rehab case mix groups. They are entitled to the best care that VA has to offer and they should not be dumped onto Medicaid, as is now the trend.

VA's budget request would have modified eligibility for long-term maintenance care to veterans in priority groups 1 through 3 and catastrophically disabled priority group 4 veterans. All other enrolled veterans would be entitled only to short-term care. Currently, VA is only required to furnish nursing home care to veterans who are 70 percent or higher service-connected disabled and to those veterans who require it because of a service-connected condition. According to VA's database, VetPop 2001 adjusted based on the U.S. census, there were 328,000 such veterans in 2000. VetPop 2001 projects the number to increase to 462,000 by 2010, and 533,000 by 2020. This represents 29 and 39 percent increases over 2000, respectively. These new criteria would open eligibility to an even larger pool of veterans.

The fiscal year 2006 VA budget request anticipates a reduction of 1,098 registered nurses, 665 licensed practical nurses and nursing assistants, and 766 technicians and allied health professionals. The American Legion is incredulous that VA would consider eliminating nearly 1,800 nursing positions at a time when VA is in the midst of a national nursing shortage crisis.

The effect of the proposed new criteria on State veterans' homes has been established, and the American Legion thanks the Committee for rejecting them this year. State veterans' homes have

been a successful cost-sharing program between VA, the States, and the veteran. Veterans in State homes tend to be without family, indigent, and requiring of aid and attendance. One State veterans' home has estimated that the changes in eligibility criteria proposed would cut its average daily census by 80 percent cost the facility $2 million per year. This proposal would have spelled financial disaster for many State veterans' homes and could well have resulted in a new population of homeless elderly veterans on our streets, especially in States with low Medicaid nursing home rates. It also has been suggested that a surge in claims for service-connection would have ensued as State homes scrambled to qualify veterans under the new criteria.

The American Legion opposes the application of the proposed nursing home eligibility criteria to the State veterans' home per diem grant program, and we support increasing the amount of authorized per diem payments to 50 percent of the cost of nursing home and domiciliary care provided veterans in State homes and full reimbursement for veterans with 70 percent or greater service-connected disability.

Finally, the fiscal year 2006 VA budget request contains no funding for State extended care facility grants programs. Instead, VA would impose a one-year moratorium on grants for new construction while VA completes a national infrastructure assessment study of its institutional long-term care. While the American Legion agrees that this study is long due—it had been left out of the CARES process—we fail to see the utility in suspending payment of construction grants in fiscal year 2006, especially in States having never previously applied and in States having great and significant need. The American Legion recommends $124 million for the State extended care facilities grants program in fiscal year 2006.

Thank you for this opportunity to present my testimony on these issues. This concludes the American Legion's testimony.

[The prepared statement of Mr. Mooney follows:]

PREPARED STATEMENT OF DONALD L. MOONEY, ASSISTANT DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to express The American legion's views on current legislative proposals concerning Department of Veterans Affairs' (VA) Long-Term Care programs. This hearing could not have been scheduled at a better time as many World War II and Korean War veterans age into a population that exceedingly relies on geriatric care facilities and professionals.

The American Legion is disturbed by VA's continuing efforts to abdicate its responsibility to America's aging veterans. This year's VA budget request contains three legislative proposals that would further those efforts. The first would repeal language in the Millennium Health Care Act that requires VA to maintain its own nursing home bed inventory at the 1998 level of 13,391. The second would change eligibility criteria for VA nursing home care and deny State Veterans Homes per diem to all but veterans in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4 veterans. The third would cut all funding for the State Veterans Homes Construction Grants Program for fiscal year 2006. The American Legion opposes all these measures.

IMPOVERISHMENT AMONG AGING VETERANS

There is currently a substantial aging veterans' population that is now and will continue to present significant demands on the Veterans' Health Administration's (VHA's) budget well into the 21st century. The ages of Word War II and Korean War veterans range from 65 to well over 90 years old. The vast majority of these

veterans live on fixed incomes with medical expenses exceeding their disposable income, especially those requiring maintenance medications to sustain their quality of life. Medical care quickly becomes a hardship for these veterans and their families. We do not need to remind the Committee that in such cases, many decisions are made about whether to buy heating fuel, food, electricity or telephone service or to pay for medicines and care required to merely to stay alive. The American Legion believes that it is a national disgrace that veterans who stormed the beaches of Europe and the Pacific, stopped the advance of communism in Korea, were held prisoners of war, suffered frostbite, contracted malaria and a host of other tropical diseases, not to mention exposure to ionizing radiation, are forced to make such decisions. How do we, as a Nation, now repay them for their sacrifices of body and psyche, of friends lost, and opportunities forsaken? We do so by keeping former President Lincoln's promise—". . . to care for him who shall have borne the battle . . . ." VA should, at a minimum, meet the mandates for long term care set forth in the Millennium Health Care Act and provide care for America's veterans at the end of their lives, when they are the most vulnerable and in greatest need.

VA NURSING HOME CARE UNIT BED CAPACITY

The President's fiscal year 2006 VA budget request contains a legislative proposal to repeal the provision of the Millennium Act requiring VA to maintain its Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. The language in the budget request refers to this mandate as "a baseline for comparison." The Millennium Health Care Act requires VA to maintain its in-house bed inventory at the 1998 level; however, this capacity has significantly eroded rather than been maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimated it had 12,239 beds in 2003 and 12,245 in 2004. The President's budget request projects only 9,975 in fiscal year 2006, a 27 percent decrease from the Millennium Act mandate. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

According to VA's FY 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated 70 percent or higher. The American Legion believes that VA should comply with the intent of Congress to maintain a minimum LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The Nation has a special obligation to these veterans. They are entitled to the best care that VA has to offer and they should not be dumped onto Medicaid, as is now the trend. Providing adequate inpatient LTC capacity is good policy and good medicine.

VA PROPOSAL TO CHANGE LONG TERM CARE ELIGIBILITY

VA's budget request for fiscal year 2006 contains a legislative proposal that would modify eligibility for long term (maintenance) care to veterans in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4 veterans. Non-catastrophically disabled Priority Group 4 and Priority Groups 5 through 8 would be entitled to only short-term care.

Currently, VA is only required to furnish nursing home care to veterans who are rated 70 or higher service-connected disabled and to those veterans who require it because of a service connected condition. According to the U.S. Census, there were 328,363 such veterans in 2000. VETPOP2001 Adjusted projects this number to increase to 462,581 by 2010 and 533,695 by 2020, representing 29.1 percent and 39.5 percent increases over 2000, respectively. An examination of the VA Long-Term Care Fact Sheet shows that State Veterans Homes ADCs will have risen between 1999 and 2004 (estimated) by approximately the same number of veterans as the decline in VA's NHU ADC.

VA may also furnish nursing home care to veterans who have service connected disabilities less than 70 percent, who were discharged from active duty because of an injury or illness incurred, were disabled due to VA medical care or vocational rehabilitation, were veterans of the Mexican border period or World War I, were exposed to toxic substances or radiation or are unable to defray the costs of care. Subject to resource and facility availability, VA may also furnish nursing home care to veterans who agree to make payments.

The FY 2006 VA Budget request anticipates a reduction of 3,299 full time equivalent (FTE) employees based on the proposed new Nursing Home eligibility criteria (PGs 1–3 and catastrophic 4s only) being enacted. Eliminated under the proposal are; 1098 registered nurses (RNs), 665 licensed practical nurses (LPNs) and nursing

assistants (NAs), and 766 technicians and allied health professionals. New mental health initiatives would, however, add 627 FTE, resulting in a net reduction of 2,672 FTE VHA-wide. Obligations by object reflect a flat appropriation for fiscal year 2006 over fiscal year 2005 ($3.49 billion for RNs and 1.05 billion for LPNs and NAs—no change). The American Legion is incredulous that VA would consider eliminating nearly 1800 nursing positions at a time when VA is in the midst of a national nursing shortage.

EFFECT ON THE STATE VETERANS HOMES PER DIEM GRANTS PROGRAM

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes (SVH) and contracts with public and private nursing homes. The reason for this is obvious; VA pays a per diem of only $59.48 (fiscal year 2004 rate) for each veteran it places in SVHs, compared to the $354.00 VA says it cost in fiscal year 2002 to maintain a veteran for one day in its own Nursing Home Care Units (NHCUs). VA NHCUs employ experienced nursing staff paid salaries comparable with State or regional locality pay rates and VA tends to fill vacancies with registered nurses rather than less skilled workers, such as nurses aides. In fiscal year 2001, 79 percent of veterans served in VA NHCUs were in the clinically complex, special care, extensive care and special rehabilitation case mix groups. These groups are the four highest resource intensive categories, resulting in a higher cost of care. SVHs, on the other hand, are required to provide the same levels of care to an increasing Average Daily Census for the VA per diem, plus whatever Medicaid, private insurance and veteran co-payments are available. Any shortfall in SVH operating revenue must come from private donations and State treasuries.

The State Veteran Homes have been a successful cost-sharing program between VA, the States and the veteran. Veterans in SVHs tend to be without family, indigent and requiring of aid and attendance. One SVH has estimated that the changes in eligibility criteria contained in the fiscal year 2006 budget proposal would cut its Average Daily Census by 80 percent and cost the facility $2 million per year. This proposal would spell financial disaster for SVHs and would result in a new population of homeless elderly veterans on our streets, especially in States with low Medicaid nursing home reimbursement rates. It has also been suggested that a surge in claims for service connection would ensue as SVHs scramble to qualify veterans for inclusion in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4. The American Legion opposes the application of the proposed nursing home eligibility criteria to the State Veterans Homes per diem grant program and supports increasing the amount of authorized per diem payments to 50 percent of the cost of nursing home and domiciliary care provided to veterans in State Veterans Homes and full reimbursement for veterans with 70 percent or greater service-connected disabilities

VA PROPOSAL TO ZERO-OUT THE STATE VETERANS HOMES CONSTRUCTION GRANTS PROGRAM IN FY 2006

Under the provisions of Title 38, United States Code (US.C.), VA is authorized to make payments to States to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 States with over 23,000 beds providing nursing home, hospital, and domiciliary care.

The Grants for Construction of State Veterans Homes provides funding for 65 percent of the total cost of building new veterans homes and about 3,500 beds per year are planned for the next 4 years. VA has not been able to keep pace with the number of grant applications; and currently there is over $120 million in unfunded new construction projects pending. Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system.

The fiscal year 2006 VA Budget Request contains zero dollars for the State Extended Care Facility Grants Program; instead VA would impose a 1-year "moratorium" on grants for new facilities construction while VA completes a nationwide infrastructure assessment study of its institutional long-term care. We fail to see the utility in suspending payment of construction grants in fiscal year 2006, especially in States having never previously applied and in States having significant need. The American Legion recommends $124 million for the State Extended Care Facility Grants Program in fiscal year 2006.

MANDATORY FUNDING FOR VHA

The American Legion believes that the current discretionary appropriations mechanism that funds VA's Long-Term Care programs remains inadequate to meet the growing demands of the veterans' community. The American Legion believes that

without significant budgetary reform, VA will continue to shift the burden of Long-Term Care onto families, communities and other Federal programs. The American Legion continues to advocate mandatory funding for VA medical care. This budgetary move would enable VA to meet its obligation to provide geriatric and other health care services for aging and service-connected disabled veterans. The passage of the Veterans Millennium Health Care and Benefits Act (Pub. L. 106–117) charged VA to provide quality Long-Term Care through VA or by contract. The American Legion believes once VA accepts a veteran as a Long-Term Care patient, no matter when or under what provision of law, the long-term care of that veteran should be provided through VHA.

CONCLUSION

Mr. Chairman and Members of the Committee, as a Nation at war; we are reminded of the hardships and sacrifices of a small portion of America—our veterans. On Memorial Day, across the Nation, we will praise veterans—past, present, and future. The thanks of a grateful Nation will echo in national veterans' cemeteries and in the halls of VA medical facilities. But regrettably, there are thousands of veterans waiting for access to VA's quality health care and even worse, hundreds of thousands of Priority Group 8 veterans will not even be allowed to enroll—regardless of their medical conditions. It is a sad commentary that when frail, elderly veterans become financially destitute, they may enroll as Priority Group 6 veterans and join their colleagues on the waiting list. Under the Administration's current proposals, even this limited opportunity for a dignified end-of-life would be foreclosed.

The American Legion believes there are better alternatives in meeting the health care needs of America's veterans:

- VA medical care should be funded as mandatory, rather than discretionary appropriations;
- VA should be recognized as a Medicare provider and be authorized to collect and retain third-party reimbursements for the treatment of allowable nonservice-connected medical conditions of enrolled Medicare-eligible veterans; and
- VA should be authorized to offer a premium-based health benefit packages (to include specialized services) to veterans with no private or public health insurance to meet their individual health care needs.

Thank you for the opportunity to present testimony on this critical issue. This concludes The American Legion's testimony.

Chairman CRAIG. Donald, thank you very much.

Fred, VA's own testimony states rather clearly that VA does not believe it can care for all 25 million American veterans in need of institutional nursing home care.

In fact, VA's proposal suggests it does not believe it can provide those services to its 7 million enrollees who may need the care. Do you agree with either of these VA assessments? And more importantly, do you believe that VA's resources are best used building new nursing homes in an effort to meet all possible needs or look at alternative care forms?

Mr. COWELL. Well, Mr. Chairman, I think it is a matter of priorities and I think the country has to decide are aging veterans worth the dollars that the country would provide to maintain the care for people who have, as was so elegantly phrased earlier by Dr. Perlin, who have borne the battle—and, I would point out, the people who bore the battle but, by the grace of God, came home whole but had nevertheless made a commitment at a time of national emergency. And irrespective of whether or not they were disabled in military service, they made that commitment and thought that they would receive these services when they returned home.

I think the financial piece of this is something that the Congress is going to have to come to grips with. We know that the Congress would like to provide as many services as possible to all veterans, and we think there is much work to be done. We are seriously concerned with the cuts in the nursing home program at a time when

increased demand is looming on the horizon. We think VA needs to take another look at this. We would ask that the Congress not provide for these budget cuts. It just seems like at a time when veterans are aging and need care the most, the VA is proposing to cut back these services, and we don't think it is good planning.

Chairman CRAIG. The priority system, passed as part of the Eligibility Reform Act of 1996, placed a higher focus and emphasis on care for service-connected disabled veterans and those with catastrophic disabilities. Yet each of you has strongly opposed VA's efforts to focus its non-rehabilitative nursing home care programs on that very population. So I am asking this of both of you: Do you believe that the priority system should not apply to the provision of nursing home care services, and would some other criteria be more appropriate?

Fred? Don?

Mr. COWELL. Go ahead.

Mr. MOONEY. Mr. Chairman, the American Legion believes that the Health Care Eligibility Reform Act was an appropriate measure for VA to prioritize its patient population. We supported that law when it was fielded back in the 1990s. We have never suggested that all veterans should be entitled to VA care—or free VA care, I should say. We have supported the idea of veterans buying into the VA health care system, those priority groups 7 and 8 that don't qualify for free care under the Health Care Eligibility Reform Act. We have never advocated that all 25 million veterans be eligible for VA care.

Chairman CRAIG. Fred.

Mr. COWELL. I think we supported the eligibility reform bill as well, and we thought it made a good attempt at trying to categorize veterans based on service connection and their financial ability to pay for health care, and we don't think that should be overlooked. I would also like to point out that the Mill Bill for the first time created eligibility for nursing home care veterans at all. Previously it was always done as resources were available. And it moved to cover service-connected conditions. It required nursing home care for veterans who were 70 percent service-connected. We think that was a good first choice.

It also grandfathered in a number of veterans who were not in those categories but who were currently residing in VA nursing home care facilities. I am troubled when I hear Mrs. Ramos talk about people who are currently residing in State veterans' homes now, who may not meet that criteria, could no longer receive funding—and where would they go? If Medicaid funding is going to cut private sector nursing home care funding and VA is going to reduce its nursing home capacity, and this hit on State veterans' homes is going to reduce and perhaps even close some State veterans' homes, I just don't see, at a time when increasing demand is right upon us, how we are going to care for these people. And I know it is a tough problem and I know you are wrestling with it. But I just think the proposals that are coming together at this time are just wrongly placed and wrongly timed.

Chairman CRAIG. Thank you, Fred.

Senator Akaka, questions?

Senator AKAKA. Thank you very much, Mr. Chairman.

As we have heard from previous witnesses. VA says that they have lagged behind in large-scale implementation of overall long-term care programs because they don't have enough resources to meet the Millennium Bill bed census requirements and expand non-institutional services at the same time.

What are your views of VA's claims? And what more do you think the Veterans' Health Administration could be doing to achieve a balance between capacities in these two areas?

Mr. COWELL. Would you like me to respond, Mr. Senator?

Senator AKAKA. Please.

Mr. COWELL. PVA—I don't think there is any veterans' service organization that has been more supportive of expansions in home- and community-based care. And I think all veterans' service organizations and all veterans understand, if veterans had a choice, obviously they would prefer to remain home as they grow older. I don't think anyone looks forward to going into a nursing home. I think the expansions in the non-institutional care programs are well-founded and I think they will serve a number of veterans well.

But I think it is naive of us to think that all veterans who need expansive care can get that care in their own home settings. I think the number of programs that VA has provided, as the GAO has pointed out, in non-institutional programs have been unevenly applied across the system. A veteran in one State may receive a full range of programs and a veteran in another State may find very limited services available. I think VA needs to do a better job in trying to regulate the Administration of their programs and make sure that they are available to all veterans across the country.

Senator AKAKA. Mr. Mooney.

Mr. MOONEY. Yes, sir. The American Legion feels that the—Could you repeat the question, sir? I am sorry.

Senator AKAKA. Yes, the question was what are your views of VA's claims and what more do you think the Agency could be doing to achieve a balance between capacities in these areas?

Mr. MOONEY. The aging in place concept of long-term care was established in Denmark and the Scandinavian countries back in the early 1970s and it has taken hold in the long-term care industry in the United States just in the last 10 or 15 years. VA is trying to catch up with that. We agree that the institutional long-term care should be the choice of last resort for elderly veterans. We supported the Millennium Act and we would like to see adequate funding given to VA to be able to implement all the pieces of the Millennium Act, both institutional and non-institutional, to get the programs that they have now fully implemented and get the population that is going to explode here shortly under control, so that they have an idea of what their resources are going to be.

Senator AKAKA. Mr. Mooney, in your testimony you touched on the financial hardships faced by many veterans as they get older and are forced to live on fixed incomes. I, too, am concerned about the overall lack of access to and affordability of long-term care. I would like you to expand on this point and tell us more about just how costly and how difficult it can be for older veterans to try and find long-term care in the private sector.

Mr. MOONEY. Oh, I don't think it is limited to veterans. I think the elderly in general have problems keeping up their utility bills and buying food and paying the rent and the heat, and they have to make a judgment as to whether they are going to do those things or whether they are going to get medical care. There is a lot of evidence that the veterans tend to be less well off than the average person. It is a given that they are going to be in the same situations.

Senator AKAKA. Thank you very much, Mr. Chairman. My time has expired.

Chairman CRAIG. Thank you very much.

Senator Obama, any questions of this panel?

OPENING STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Mr. Chairman, thank you very much. I apologize for missing the first panel. We have a Bolton hearing going on right now and, as you know, that is taking a lot of time in the Foreign Relations Committee.

I had the opportunity to review the testimony. I think the questions that were asked by the Chairman and the Ranking Member were on point. I would just point out that long-term care is especially important to the State of Illinois. I am proud to say that Illinois was the first State in the Union to have a State veterans' home. We are proud of being a pioneer in veteran long-term care. That proud legacy of care is threatened by the passage of the recent Federal budget, but I am thankful that this Committee turned back some of the cuts that had been proposed with respect to reimbursement systems that would have a severe impact on the State of Illinois.

So I just appreciate the Chairman and the Ranking Member hosting this important hearing. I thank the witnesses and will continue to monitor the situation carefully.

Chairman CRAIG. Gentlemen, thank you both very much for your presence and your testimony and, obviously, the commitment of your organizations to America's veterans. This hearing was intended to be a dialogue to begin to build a record to look at the broader aspects of long-term care, and also the current commitment, or lack thereof, of the Veterans' Administration as it relates to long-term care directed by current laws that this Congress has enacted. And we will stay with this as the issue grows and work with all of you to make sure that we can do as much as is possible to do under our current constraints. At the same time, as you both have recognized and we appreciate that, this Committee is willing to push the limit and get beyond that where necessary and important to do so.

We also thank our State homes people for being with us today. That is sometimes, at least at the Federal level, a forgotten—but if you are at the State level, a clearly recognized and necessary service to America's veterans, and we appreciate their presence, too.

So thank you all very much for being here today.
The Committee will stand adjourned.
[Whereupon, at 11:48 a.m., the Committee was adjourned.]

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