THE STATE OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS LONG-TERM CARE PROGRAM PRESENT AND FUTURE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MAY 9, 2007

Serial No. 110–21

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

35–640 WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida
VIC SNYDER, Arkansas
MICHAEL H. MICHAUD, Maine
STEPHANIE HERSETH SANDLIN, South Dakota
HARRY E. MITCHELL, Arizona
JOHN J. HALL, New York
PHIL HARE, Illinois
MICHAEL F. DOYLE, Pennsylvania
SHELLEY BERKLEY, Nevada
JOHN T. SALAZAR, Colorado
CIRO D. RODRIGUEZ, Texas
JOE DONNELLY, Indiana
JERRY MCNERNEY, California
ZACHARY T. SPACE, Ohio
TIMOTHY J. WALZ, Minnesota

STEVE BUYER, Indiana, *Ranking*
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
RICHARD H. BAKER, Louisiana
HENRY E. BROWN, JR., South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas
GINNY BROWN-WAITE, Florida
MICHAEL R. TURNER, Ohio
BRIAN P. BILBRAY, California
DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida
VERN BUCHANAN, Florida

Malcom A. Shorter, *Staff Director*

SUBCOMMITTEE ON HEALTH

MICHAEL H. MICHAUD, Maine, *Chairman*

CORRINE BROWN, Florida
VIC SNYDER, Arkansas
PHIL HARE, Illinois
MICHAEL F. DOYLE, Pennsylvania
SHELLEY BERKLEY, Nevada
JOHN T. SALAZAR, Colorado

JEFF MILLER, Florida, *Ranking*
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
RICHARD H. BAKER, Louisiana
HENRY E. BROWN, JR., South Carolina

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

May 9, 2007

THE STATE OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS LONG–TERM CARE PROGRAM PRESENT AND FUTURE

WEDNESDAY, MAY 9, 2007

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

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Hare, Salazar, Brown of South Carolina.

Also present: Representative Walz.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. The Subcommittee will come to order. I would like to thank everyone for coming today. Before I begin, I would ask unanimous consent that Mr. Walz of Minnesota be invited to sit at the dais of the Subcommittee hearing today. Hearing no objection, so ordered.

This morning the Subcommittee on Health will examine the state of VA's long-term care programs and services. In terms of demographics, the veterans population is aging and will require a great amount of long-term care services. Out of a veterans population in this country of 25 million, nearly 45 percent are over the age of 65 and the number over the age of 80 is expected to reach 1.3 million by 2010. In addition, the veteran population is poorer, sicker and older than their non-veteran counterparts.

The VA will also be facing an entirely new generation of veterans in need of long-term care services, some of our wounded returning Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans who have different needs than those of our older veterans. Medicaid is a principal financer of long-term care. In 2004, Medicaid spent $90 billion on long-term care services, of which $57.6 billion, or 64 percent, was for institutional care.

The VA has requested $4.6 billion for long-term care services in fiscal year 2008. Nearly 90 percent is for institutional care. The VA must, in my view, maintain its nursing home capacity, while vigorously expanding its non-institutionalized care capabilities. Contrary to the plain evidence of an increased long-term care demand, this year the VA will again ignore its clear legal responsibility to maintain its nursing home bed capacity.

The VA's fiscal year 2008 budget estimates a further drop in the average daily census to 11,000, nearly 20 percent below the required level. I am concerned that VA is not doing enough to maintain its nursing home capacity, while not moving fast enough to provide more home and community-based care.

An integral component of the VA's institutional care service is the State Veterans Home Program. Currently, State Veterans Homes handle over 50 percent of VA's overall patient workload in nursing homes. I believe we must maximize this existing resource, as well as other resources within our communities, to ensure the best possible care for our veterans.

The VA has a long history of providing long-term care services and I believe that the VA has many lessons it can teach other areas of the Federal Government and the private sector on how best to provide these services. The VA can, indeed, be a long-term care model for others.

VA continues to have an obligation to meet the long-term care needs of our veterans and I look forward to hearing from our witnesses today as to how the VA should meet this obligation in the future.

It is now my distinct pleasure to recognize the Acting Ranking Member, a Member who I have served with ever since I came to the Veterans' Affairs Committee in different capacities, when I first became Ranking Member of the Benefit Subcommittee. Then the distinguished Chairman was Chairman Henry Brown. Following that Congress, I became Ranking Member of the Healthcare Subcommittee. At that time the distinguished Chairman was Henry Brown.

And Mr. Brown has actually taken time out to come to the State of Maine to look at rural healthcare issues and likewise, I have gone to his State to look at issues in his State. And I really appreciate his understanding of veterans issues, as well as his willingness to fight for veterans' healthcare. So I would yield to the acting Ranking Member, Henry Brown.

[The prepared statement of Chairman Michaud appears on p. 34.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Well, thank you, Mr. Chairman, and it has certainly been a pleasure of mine to serve alongside of you in many different capacities. But in all the capacities we have served together was to better enhance the quality of healthcare for our veterans and I commend you for your continuation along this path.

I am grateful for the Members testifying before the Committee this morning, and I have met some you earlier and I look forward to hearing your testimony. I do have some opening remarks and I will be brief.

Today, one of the biggest challenges in both VA and the private sector healthcare system is providing long-term care to a growing aging population. This challenge is amplified for VA which must facilitate care for the special needs of our disabled and aging veterans. The Department is also facing an emerging new need to care for seriously injured younger veterans returning from the Global War on Terror.

I appreciate at our hearing today we have witnesses representing the States Veterans Homes. On Veterans Day last year, I had the privilege of dedicating a new State Veterans Home in Walterboro, South Carolina. This 220-bed facility, the Veterans Victory House, is one of the most modern of its kind in the United States and includes a 52-bed secured dementia unit.

In partnership with the VA, State Veterans Homes can help provide a broad range of service to meet the long-term care needs of our veterans. Last year with the enactment of Public Law 109–461, the Veterans Benefits, Healthcare and Information Technology Act of 2006, Congress expanded the authorities for State Veterans Homes. The law requires VA to reimburse State Veterans Homes for the full cost of care for a veteran with a 70 percent or greater service-connected disability rating and in need of care for service-connected conditions. It also ensures that veterans with a 50 percent or greater service-connected disability receive, at no cost, medications they need through VA.

Additionally, Public Law 109–461 requires VA to publish a strategic plan for long-term care. Hopefully, this plan that has been a long time in coming will provide a clear map of the Department's future plans for delivering long-term care for those veterans who rely on VA to provide these services. I look forward to the delivery of this plan as required by law. We have allowed VA to drag its feet on this issue for far too long.

Mr. Chairman, we need to remember that the quality in which we provide long-term care is a reflection on how this country honors the sacrifices of our Nation's veterans.

I look forward to our discussion today and to explore innovative steps we can take to provide the best patient centered care to enhance the quality of life of veterans in need of long-term care services.

Knowing that was a busy day this is, I yield back the balance of my time and look forward to hearing from the witnesses. Thank you, Mr. Chairman. It is a pleasure to be here today.

[The prepared statement of Mr. Brown appears on p. 34.]

Mr. MICHAUD. Thank you, Mr. Brown. Mr. Walz, any opening statement?

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Just to keep it short for you, Mr. Chairman. First of all, I would like to thank you and the acting Ranking Member Brown for allowing me to be here. But more importantly, I would like to thank you for your long service to our veterans and your commitment to them. It is something that is well-known and I appreciate everything you have done.

I would also like to thank Mr. Nagel and Mr. Griffith for being here today.

As a 24-year veteran of our armed forces and someone who is deeply concerned with these issues here, I am here today because of a re-occurring issue that keeps coming up in Minneapolis with our Veterans Home there and it has been ongoing for quite some time. And I know that everyone in this room is here to be committed to the care of our veterans and to figure out the best way to do that. So I am here to listen to your expertise, listen to our

Chairman and Ranking Member and try and figure out what we can do best to help you provide the care for our veterans and do it in a way that we avoid some of these problems.

So I thank the Chairman and I yield back.

Mr. MICHAUD. Thank you very much, Mr. Walz. We really appreciate your ongoing commitment to our veterans, as well as your service to this country. I appreciate that.

I will now ask unanimous consent that all written statements be made part of the record. Without objection, so ordered.

Mr. MICHAUD. And I also ask unanimous consent that all Members be allowed five legislative days to revise and extend their remarks. Without objection, so ordered.

The first panel, it gives me a pleasure to introduce Raymond Nagel who is the Chief Executive Office of the Maine Veterans' Home, as well as Mr. Roy Griffith who is Chairman, Liaison Committee for the National Association of State Veterans Homes. I look forward to both of your testimony and we will start out with Mr. Nagel.

STATEMENTS OF RAYMOND A. NAGEL, CHIEF EXECUTIVE OFFICER, MAINE VETERANS' HOMES, AUGUSTA, MAINE; R. ROY GRIFFITH, CHAIRMAN, LIAISON COMMITTEE, NATIONAL ASSOCIATION OF STATE VETERANS HOMES, AND ADMINISTRATOR, OKLAHOMA VETERANS CENTER, TALIHINA, OKLAHOMA

STATEMENT OF RAYMOND A. NAGEL

Mr. NAGEL. Good morning. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today on behalf of the Maine Veterans' Homes on long-term care. My name is Ray Nagel. I am the chief executive officer of Maine Veterans' Homes. I have 23 years of healthcare experience, including 21 years as a medical service corp. in the United States Army and the United States Army Reserve. I am a combat veteran of Operations Desert Shield and Desert Storm.

The Maine Veterans' Homes runs six long-term care facilities. We operate 640 skilled nursing, long-term nursing and domiciliary beds and we are very proud of the quality of the long-term care that we provide.

Our facilities are relatively small in size, 30 to 150 beds each. They are located throughout the State of Maine allowing greater access for veterans living in the rural parts of our State.

We greatly appreciate the Subcommittee's commitment to long-term care needs of veterans and your understanding of the indispensable function that State Veterans Homes perform. We especially appreciate the consistent support of the Veterans Affairs' Committee and your colleagues on the Appropriations Committee to ensure that per diem payments by the VA will continue under current eligibility criteria.

As a Nation, we face the largest aging veterans' population in our Nation's history. By the end of this decade, the number of veterans over the age of 85 will have tripled to over 1.3 million. The State Homes now provide about 50 percent of the VA's total long-term care workload and we should be treated as a resource that is

integrated much more fully with the VA's own long-term care program.

The State Homes have proposed that our beds be counted toward the VA's overall long-term care census which will allow the VA to meet its statutory requirements. Congress' goal should be to provide long-term care in a manner that expands the VA's capacity, while paying the lowest available per capita cost.

The VA reports that the average daily costs of care at a VA long-term care facility is over $560 a day. The same costs of care to the VA at a contract nursing home is more than $225 a day. That same cost to the VA for long-term care at a State Home is far less, a per diem of under $68 a day. I will repeat, $68 a day.

This substantially lower daily cost to the VA of the State Veterans Homes compared to other available long-term care options led the VA Inspector General to conclude that State Homes are an economical alternate to contract nursing homes or VA medical center nursing home care.

The State of Maine, with 640 beds already in operation, has built all of the long-term care beds for veterans that we expect to build. Furthermore, we operate our long-term care beds at 96 percent capacity.

If the State of Maine is to provide greater levels of service to its veterans, Maine Veterans' Homes must expand the types of services that we provide. At our 150-bed Bangor facility, we are proposing to construct an integrated veterans campus containing a community-based outreach clinic commonly called a CBOC, a seven-bed hospice facility, and an 18-unit housing facility.

Attached to my testimony are site plans for this veterans campus. This campus can be constructed using solely the financial resources of Maine Veterans Homes, at no cost to Maine's taxpayers. Later, the services provided could be expanded to include assisting living in congregate housing, adult daycare and home healthcare. Our goal is to provide with an integrated setting comprehensive healthcare services covering the full continuum of care.

Furthermore, this concept could be replicated at our other five facilities in order to provide the veterans throughout the State of Maine with easier access to comprehensive healthcare, both in rural and urban settings. This concept of veterans campus could be a model for other States.

Mr. Chairman, we thank you for your support of this concept and we look forward to welcoming you to the formal announcement of our plans at our Bangor facility.

In conclusion, we believe that the State Veterans Homes can play a much more substantial role in meeting the long-term care needs of veterans. We would be pleased to work with the Committee and the VA to explore options for developing pilot programs for innovative, long-term healthcare solutions and for more closely integrating the State Veterans Homes' programs into the VA's overall healthcare system.

Mr. Chairman and Members of the Subcommittee, I would be pleased to answer any questions you may have of me at this time.

[The prepared statement of Mr. Nagel appears on p. 35.]

Mr. MICHAUD. Thank you very much, Mr. Nagel.

Mr. Griffith.

STATEMENT OF R. ROY GRIFFITH

Mr. GRIFFITH. Mr. Chairman and Members of the Subcommittee, I want to thank you for inviting the National Association of State Veterans Homes (NASVH) to testify on the role that State Homes do and can play in the VA provision of long-term care.

I especially want to thank you for allowing me to substitute for our national Legislative Chair, Bob Shaw, who was unable to make it to today's hearing due to the recent death of his mother.

This morning I am speaking to you as a member of NASVH's Executive Committee and Chairman of our VA Liaison Committee where I am responsible for interfacing with the Department of Veterans Affairs. In addition, I am here as Administrator of the Oklahoma Veterans Center, Talihina, Oklahoma, which provides long-term care to 175 veterans, which includes 48 beds for dementia patients.

Mr. Chairman, with the aging of our baby boomer generation, America faces a looming long-term care crisis, one that many of our Nation's veterans already know too well. VA provides that today's veteran population of 24.5 million will continue to fall through 2020, but that the number of veterans over 65 years of age will rise and ultimately peak in the year 2014, driven by the very large number of Vietnam veterans. Most alarming, the number of veterans over the age of 85 is projected to increase by 173 percent by 2020, creating an even greater number of veterans seeking long-term care.

Mr. Chairman, it is clear that the long-term care needs of veterans will continue increasing in the coming years and VA must have a fully developed plan to provide that care. Earlier this year, in response to a request by VA, NASVH surveyed a number of State Homes to determine the current unmet demand for State Home care. We found substantial waiting lists which indicate as many as 10,000 veterans currently waiting to get into State Homes, and we believe that there are many more who don't even bother to put their names on these long waiting lists.

Mr. Chairman, State Homes today already provide the bulk of long-term care for our Nation's veterans, with more than 28,000 beds of which 22,000 are skilled beds. Last year the U.S. government Accountability Office (GAO) reported that State Homes provide more than 50 percent of VA overall patient workload in nursing homes, while consuming just 12 percent of the VA's long-term care budget. And the trend over recent years shows that State Homes are increasing their share of workload while their share of VA's budget continues to decline. VA pays just $67.71 as a per diem payment for each veteran residing in a State Home, which is less than one-third of the average cost of that veteran's care.

Compare this to VA's cost when contracting out with community nursing homes with VA covers a hundred percent of the cost, often upward of $200 per day, or when VA provides the care through one of its own nursing homes where the average cost of care is excess of $500 per day.

Clearly, an investment in State Homes represented an efficient use of taxpayers' dollars, one that we hope will continue to receive the strong support it has in the past from the Committee. The State Homes Program gives you the biggest bang for your buck.

However, we are deeply troubled by recent cuts in the State Home Construction Grant Program over the past 2 years, which is down from $104.3 million to $85 million, which is a total funding reduction of approximately $40 million in the last 2 years.

As a result of these real dollar reductions, as well as the effects of inflation and rapidly rising construction costs, the backlog of State Home construction projects is rapidly rising. There are currently $242 million in priority one projects, those that repair life and safety issues in the homes. NASVH estimates that the total backlog of all potential qualifying State Home projects could soon surpass $1 billion. Congress must increase this funding level to at least $160 million in FY 2008 in order to reduce the rising backlog, address the most serious life and safety issues, and protect the State Homes system for the future.

Mr. Chairman, since the Civil War, States have assumed the burden of care for veterans and today spend over $3 billion annually to provide this care, despite the fact that veterans of our armed forces are serving the whole Nation, not just their States. Seen this way, the care rendered to veterans by the States actually constitutes a subsidy to the Federal Government.

Finally, Mr. Chairman, I would like to ask you and this Subcommittee to help ensure that VA moves forward with regulations necessary to implement legislation that has already passed Congress. In 2004, Congress approved, and the President signed Public, Law 107–422 which authorized a scholarship program to help nurse recruitment and retention in State Homes, where there is a serious nursing shortage.

This program is modeled on a similar program that the VA currently operates, yet more than 3 years after the enactment, we are still waiting for implementing regulations. Last year, with your strong support, Congress passed legislation that provided service-connected veterans in State Homes with equity, both in receiving prescription medications and the 70 percent service-connected veterans would receive full cost of care. We are still awaiting these very important regulations. While we have had hopeful talks with the VA about this progress, we believe a bit of oversight by Congress can help ensure that all these regulations come into force this fiscal year.

Mr. Chairman, this concludes my testimony and I would be pleased to answer any questions you might have.

[The prepared statement of Mr. Griffith appears on p. 38.]

Mr. MICHAUD. Thank you very much, Mr. Griffith and Mr. Nagel for your enlightening testimony. I have a couple of questions.

The first one to Mr. Nagel. You mentioned that you plan on developing a veterans' campus in Bangor and I think that is a real innovative approach of what you are looking at, taking hospice and adult daycare and what have you. And you are looking at other facilities within Maine. Is Maine unique or do you think other States can take that approach? Have you talked to other State Veterans Homes in other areas?

Mr. NAGEL. That is a very good question, Congressman. I believe that the system that we are starting can be replicated pretty much anywhere across the country. I think it works extremely well on Maine's behalf because we are by large a rural State, and by con-

solidating the veterans' resources at the Federal, State and local levels, it allows those veterans in those rural areas to come to one spot instead of driving many, many miles out of their way to receive the care at the different levels.

I would be very happy to share this with other States and I am sure that once our prototype is finished—and it will be successful—that it will be a pilot project for other States in the future.

Mr. MICHAUD. Thank you. I have been to the facilities in my other capacity when I was in the State Legislature, so I am very familiar with the facilities and thank you for thinking outside the box.

My next question is actually for both gentlemen, since you deal with different States, when you look at the cost difference for the VA for State Veterans Homes versus what the VA provides, there is a big difference. However, do you think that the current capacity—I know for Maine, you said you pretty much do not intend to build any more right now—do you think that there is capacity out there throughout the country to take additional beds?

Mr. GRIFFITH. You can tell by looking at the request for construction, the States wanting to build, especially in the areas like California, Texas, Florida, where there is a real large veteran population and not that many State Homes. There is definitely an interest for the States to build more beds.

Mr. MICHAUD. And how long do you think that process will take if we provided adequate funding?

Mr. GRIFFITH. Not long. The States—to get to priority one, those numbers I gave you earlier—to be a priority one, the State already has the matching funds available, which means you give them the Federal funds and they start to build. They already have to have their architectural stuff already done and taken care of, so if Congress funds their side of it, the State is going to immediately bid it out and start building, because to get to priority one, you already have to have your State funds available.

Mr. MICHAUD. Mr. Nagel, you mentioned you are pretty much at capacity now. Do you envision that there is going to be a greater need, particularly with the war in Iraq and Afghanistan for additional beds in Maine? And are you prepared to expand if need be?

Mr. NAGEL. We are prepared to expand in the future if the studies indicate that there will be an increased need in the future. I wouldn't anticipate that the veterans that are returning right now would be requiring our long-term care needs, but that is certainly something to be considered for the future.

And to echo what my association has already said, I also believe that the other States—there may not be more reason to build more beds in Maine, but there is great reason to build State Homes in other States that have the need and the capacity. And there is a very good system for indicating the level of need by State.

Mr. MICHAUD. Okay. My last question—and I see I am running out of time—do you feel that State Veterans Homes have the capacity to take care of our newer veterans in terms of traumatic brain injuries (TBI)?

Mr. GRIFFITH. That is more of a specialized care. We are more long-term care. That is kind of what the VA in my opinion—the specialty care should be done by the VA and we take care of what

we call the primary care. Now, in Oklahoma, I do IV therapy in-house and we have all—so we are really a step above a private nursing home, because, you know, if you catch pneumonia and you are at the veterans center, we are going to put you on a IV and treat you at the veterans center, where if you are in a private-sector home, they are going to ship you to the hospital and collect these big dollars from the hospital for your care there. So we are kind of a—but the specialty care, I take—in Oklahoma, we don't do dialysis nor ventilator-dependent. Those are the only two long-term cares that we can't manage there.

Mr. MICHAUD. Okay.

Mr. GRIFFITH. In my opinion, that is what the VA should be doing is this specialty stuff.

Mr. MICHAUD. Okay. So for anyone who needs long-term care that has TBI, you feel that this is best left with the VA system?

Mr. GRIFFITH. Yes.

Mr. MICHAUD. Okay. Great. I thank you.

Mr. Brown, do you have any questions?

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

And thank you, gentlemen, for this informative briefing. Let me see if I can get some clarification on this. You state that the VA pays only about $68 a day to provide long-term nursing home care at State Veterans Home. However, Public Law 109–461 requires VA to reimburse State Veterans Homes for the entire cost of care for service-connected disabled veterans rated 70 percent or higher for a veteran in need of which such care for a service-connected disability.

What is your estimate of what VA will be required to pay for the care of these veterans under Public Law 109–461?

Mr. GRIFFITH. They give us five options. We have met with the VA, our association has, on this topic. There is five different options that they can do. It could go anywhere from the local Medicaid rate, the Medicare rate, their local contract rate, cost of care of our Homes nationally or regionally. So there is like several different ways it can go. Mine is, we need to the VA to hurry up and get us some regulations.

I have already got families at home that saw this law passed and are wondering why I am still charging them. They are having to pay for part of their care. And I said well, until the VA promulgates these rules, I have no way of, you know—you are entitled to this.

The law passed December 22nd. It became law March the 22nd. But the way—it is just like the nurse recruitment thing I was telling you about. It happened in 2004. We still have no regulations on it and we are afraid the 70 percenters are going to go the same route if something doesn't happen. These veterans are going to be sitting out there which deserve full cost of care.

They are actually being drove to a private nursing home to get a lower level of care for free instead coming into the State Veterans Home and get a higher level of care, but they have to pay for part of that care. And that is just not right.

Mr. BROWN OF SOUTH CAROLINA. What percent are they having to pay now?

Mr. GRIFFITH. Sir?

Mr. BROWN OF SOUTH CAROLINA. What percent will they have to pay?

Mr. GRIFFITH. Seventy percent or more.

Mr. NAGEL. No. What percentage do they have to pay?

Mr. BROWN OF SOUTH CAROLINA. Right. I mean what would be their co-payment?

Mr. NAGEL. It depends on what type of funding source that they have. If it is Medicare, Medicaid, and Medicaid would vary by State.

Mr. GRIFFITH. Every State is a little bit different. In Oklahoma, for a married veteran it is 50 percent of total family income, 85 percent for a single veteran. So they are having to actually pay for their care by using part of their pension, and that is not what it is for. And the law specifically states that they shouldn't pay.

Mr. BROWN OF SOUTH CAROLINA. Why is it such a differential between the VA nursing home and the State Veterans Home?

Mr. NAGEL. I can answer that, sir. In Maine, we operate under a competitive model. We take the stipend money that we receive from the VA and we apply that to our veteran population. And in addition, as opposed to appropriating money from the State of Maine for our budget, we act as a competitive nursing home, just like any other for-profit company, although we are a public not-for-profit organization.

So under our system, we bill Medicare and Medicaid and as a result, our veterans receive superb quality of care because we are competitive. And we are no different than any other nursing home chain in that aspect. We are held to the same standards, same quality standards and even more, because we have to be inspected by both the VA system, as well as our State systems. And it actually has proven to be a very cost effective as well as efficient model.

Mr. GRIFFITH. I have got another little approach that—I have been the Liaison Chairman of the National Association of State Veterans Homes for the past ten years and I have always been curious about how the VA actually costs their stuff out. You know, I don't know where they came up with the dollar figures so high. In Oklahoma, we provide—we have doctors on staff or on pharmacy, laboratory, ventilation therapy and our costs are around $220. So I don't know how they come up—but the numbers are there and it is their numbers we use. They are extremely high, but—

Mr. BROWN OF SOUTH CAROLINA. So the $560 is a pretty representative number you think?

Mr. GRIFFITH. Those are VA's numbers we are using. I don't know how they come up with them, but it is their numbers and they are extremely high.

Mr. BROWN OF SOUTH CAROLINA. Okay. Thank you, gentlemen, thank you.

I will yield back the balance of my time.

Mr. MICHAUD. Mr. Walz?

Mr. WALZ. Thank you, Mr. Chairman.

And thank you both for your testimony and the work that you are doing. The need for our veterans' care, long-term care is unquestionable and growing and we see that and it is a trend we have to take into consideration. And I do appreciate what the State

Veterans Homes have done in terms of efficient, effective care for our veterans.

I am trying to understand the relationship between the VA, the Veterans Homes, the States and how this works. I am coming from this from the perspective in Minnesota that our VA hospital in Minneapolis is a polytrauma center, recognized as one of the best I would say in the world. The care is outstanding.

Three blocks away we have our State Veterans Home and it has had continuous issues that are coming up of care, serious issues. And my question is on this and on the funding is, the way that this has been dealt with—and I have watched this evolve over the past couple years and I am deeply concerned with it—is that violations result in punitive financial hold-backs from the institution, from the State Veterans Home.

And I question, I ask both of you, is this the most efficient way to get and expect change when we are withholding money that is making it more difficult for them to take veterans in and to provide the care and it seems that it has spiraled into a continuous set of violations that has now rippled out into other things that I think may be attributable to the lack of resources.

Perhaps the withholding of wages from the people involved with that might have been more efficient. But please, if you could help me understand this on this funding issue and why they are doing it this way. And they are under threat now that the Federal Government in June is going to cut all funding to them, which will basically shut them down at a time when we need them. So if you could help me with this?

Mr. GRIFFITH. It is a VA rule as far as I know. That is the only leverage they have over a State Home is to pull your per diem. And that is what—but if they did, if you are having problems because you are not paying staff enough, you are not getting good staff, you need some facility changes, whatever, if they cut your money—well, right now, if the VA would jerk per diem, the State Home Program would cease to exist because there is no way they could operate.

So if you are already in a problem because you need more money to get better staff—well, I don't think pulling your money would be a very good solution from where I am sitting at.

Mr. WALZ. But our only option is the staffs, the VA to change that—the way they go about it apparently right now. I am very frustrated by it because it hasn't worked in the past and they have tried it several times. They are continuing to do per diem pulls every day on this thing and I am—it just seems to me we are in a situation we are going to lose that home. It is spiraling down and I have deep concern over that.

So what would your suggestions be on this? And I ask you not—I know you don't know the specifics maybe of that institution. But how would you handle it?

Mr. NAGEL. May I——

Mr. WALZ. Sure.

Mr. NAGEL. That is a really good question. And I am not exactly sure how the system operates in Minnesota. But I can tell you that in Maine we look at this from a preventative standpoint. We have extremely tight, stringent internal controls. And because we operate as a competitive type of facility as opposed to a State institu-

tion or an appendage of the State, we have two sets of internal control mechanisms that we have to respond to at least twice a year. And that is the VA oversight which is pretty strict——

Mr. WALZ. Right.

Mr. NAGEL [continuing]. As well as the State and Federal Medicare or Medicaid guidelines. Now, in States that don't participate in Medicare or Medicaid, they won't have those guidelines that they have to follow as well. So in Maine, we have the guidelines that we have to meet under Medicare/Medicaid, as well as the VA and we also initiate—because we do operate as a private type of organization, we have a very, very strict peer review council where members of different disciplines go from one home to another and they do pre-evaluations on those homes and they are pretty scathing and it keeps us in line.

So in a nutshell, what I will tell you is that we basically look at it from a preventative standpoint and that by doing that, it helps to avoid the costly penalties that would happen. Now, and one more thing is that the VA's penalizing of stipend, I would not agree with it either. But it is no different, honestly, than what Medicare does. And Medicare does what is called a civil monetary penalty, Medicare/Medicaid. So if you have deficiencies, they fine you. So it is very similar in that regard.

Mr. WALZ. Very good. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. My apologies for getting here a little late. So if the questions that I am asking have already been covered, I hope you will bear with me. There have recently been reports that some of the State Veterans Homes aren't safe or the quality of care isn't what it should be.

How can the VA better ensure that these homes perform to the national standards that are required of them? What can we do or what should the VA be able to do to get these homes up to standard?

Mr. NAGEL. Personally?

Mr. HARE. Sure.

Mr. NAGEL. Personally I think that the State Homes should be following both the VA standards as well as the Medicare/Medicaid guidelines. If they are following Medicare or Medicaid guidelines, they are going to have two sets of eyes that are looking at them all the time. And that is a built in internal control mechanism that ensures quality to the patients.

Mr. GRIFFITH. That is one thing our association has talked about for years with the VA, is why the VA doesn't use CMS guidelines. The VA writes their own regulations. CMS has got theirs. We are being inspected by two different sets of regulations. With being two Federal agencies—and this is my personal—I don't know why that we are not inspected by the CMS regulations. Because if you are Medicare or Medicaid, CMS comes in with their regulations, VA comes in with their regulations. And we are like them. We have a peer review of our own internal agency that does our own peer review which in Oklahoma is tougher than the other two.

But they are all using different sets of regulations and mine is, I don't know why that the VA and CMS doesn't get together, or the VA use their regulations. I mean because they are tough and they provide—they are geared toward quality of care. But we in the field have to kind of dance to both tunes at the same time.

Mr. HARE. Okay. Thank you. Mr. Griffith, you mentioned in your testimony that the State Homes in Oklahoma are developing programs or plans for more adult day healthcare programs and other approaches to developing care in less restricted settings. I wonder——

Mr. GRIFFITH. Yeah, it is in Maine. We are not doing adult day healthcare in Oklahoma yet.

Mr. HARE. Okay. Well, I am wondering if you could elaborate on what other emerging approaches, other things that you are doing and is this just restricted to the State or are there other State Homes trying to do the same?

Mr. NAGEL. Well, we are trying to bring—there is an idea in the Army and it is called far forward medicine. And in Maine they didn't call it that, but they thought of it before the Army did. And I think they did it out of necessity because the State is pretty rural.

So rather than—in certain States they have large compounds where the State Veterans Homes are at. In Maine they decided to build smaller facilities, but locate them all over the State so that it would serve that area of the State. So it is much more patient friendly, if you will.

And taking that one step further and thinking outside of the box, what we have done is, we have such a good relationship in Maine between all levels of the veterans service organizations, whether it is at the Federal level, State, community, local. We have gotten together with all of them and we have decided to take that idea one step further and try and put the Federal, the State and the community veterans services on one little campus, on those campuses so that they don't have to travel to numerous places to receive the services that they are entitled to.

And we are starting with our Bangor campus because it is a proven facility. We have willing partners there. And the VA hospice physician approached us asking us to open up a hospice there. So we have plans to open up a hospice, a seven-bed hospice there adjacent to our facility, which is something that I think that the VA should actually start paying a stipend for, because I think that is a big——

Mr. HARE. I agree.

Mr. NAGEL [continuing]. Need. We are also opening up—we are hoping to link with the VA and open up a community-based outpatient clinic which right now is located a couple miles away. And this way they would—our same residents would be able to access medical care there with the doctors that they already see. And we are hoping possibly 1 day to build maybe adult daycare, as well as veteran housing. So those are the programs that we are looking at currently.

Mr. HARE. That is great. Thank you very much, Mr. Nagel.

I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Salazar.

Mr. SALAZAR. Mr. Chairman, I have no questions at this time.

Mr. MICHAUD. Thank you.

Before we release the panel, I just want to ask one question of Mr. Griffith.

You mentioned the two different regulations between the VA and the CMS. Which is the tougher of the two?

Mr. GRIFFITH. The CMS.

Mr. MICHAUD. The CMS, okay.

Mr. GRIFFITH. Seems to be. I am not survey, but a lot of the States are. Maine is one of them. Colorado is one. Ours is, we just—and we have asked this—as Liaison Chairman, we meet with the VA twice a year and we have asked for this one reg for years and there is one reason or another we haven't done it. But it really makes a lot of sense that if you are being inspected, you should be inspected by one regulation.

Mr. MICHAUD. Great. Well, once again, I would like to thank both of you gentlemen for your testimony and answering questions. It has definitely been very helpful. So thank you both very much.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Mr. NAGEL. Thank you, sir.

Mr. MICHAUD. I would ask the second panel to come forward. The second panel consists of Shannon Middleton, who is the Deputy Director of Healthcare, Veterans Affairs and Rehabilitation Commission for the American Legion, Mr. Adrian Atizado, who is the Assistant National Legislative Director for Disabled American Veterans, and Fred Cowell, who is the Senior Associate Director, Health Analysis for the Paralyzed Veterans of America. I want to thank all three for coming today. I look forward to hearing your testimony. And we will start with Ms. Middleton.

STATEMENTS OF SHANNON L. MIDDLETON, DEPUTY DIRECTOR, HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND FRED COWELL, SENIOR ASSOCIATE DIRECTOR, HEALTH ANALYSIS, PARALYZED VETERANS OF AMERICA

STATEMENT OF SHANNON L. MIDDLETON

Ms. MIDDLETON. Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on VA's strategic direction and plans to address the aging veteran population and the needs of recently separated veterans.

A July 1984 study, "Caring for the Older Veteran," predicted that a wave of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA long-term care system if not properly planned for.

The study cited an imminent need to provide a coherent and comprehensive approach to long-term care for veterans. Twenty-3 years later, the comprehensive approach prescribed has yet to materialize.

The American Legion supports a requirement to mandate that VA publish a comprehensive long-term strategic plan. In recent testimony, GAO indicated that veterans' access to noninstitutional long-term care was still limited by service gaps and facility restrictions. GAO assessment demonstrated that for four of the six services, the majority of facilities did not offer the services or did not provide access to all veterans living in the geographic area.

On the issue of nursing home care, VA has been equally resistant in complying with the mandates of the Millennium Act. The Act required VA to maintain its in-house nursing home care unit bed capacity at the 1998 level.

The American Legion believes that VA should be required to restore its nursing home care unit capacity as intended by Congress to the 1998 level. Additionally, VA should be prohibited from including any but their own nursing home care unit beds for the purpose of compliance with the provisions of the Millennium Act.

VA claims it cannot maintain both the mandated bed capacity and implement all the requires of the Millennium Act. The American Legion believes VA should provide the quality of care mandated by Congress for the long-term care of America's veterans and Congress should provide adequate funding to VA to implement its mandates.

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes and contracts with public and private nursing homes. Currently, VA is authorized to make payments to State for construction and maintenance of State Veterans Homes. Recognizing the growing long-term healthcare needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative healthcare provider to the VA system.

In testimony delivered in 2006 addressing VA long-term care, GAO identified estimating which veterans will seek care from VA and what their nursing home needs will be as a major challenge in VA's ability to plan for nursing home care. The unpredictability of long-term care needs of those suffering from polytrauma, blast injuries and lasting mental health conditions as a result of participation in the ongoing Global War on Terror will no doubt make planning even more challenging.

The Commission on the Future for America's Veterans was established to ascertain the needs of veterans 20 years in the future. The Commission has been conducting townhall meetings around the country to allow veterans, family members and caregivers an opportunity to express their views on the future needs of servicemembers, especially those who have been injured in the current Global War on Terror.

At the conclusion of this fact finding initiative, the Commission will create a report that will include recommendations for addressing the needs identified. The Commission plans to deliver recommendations to the President, Congress and the American public by Memorial Day 2008 and the American Legion supports this timely and proactive endeavor in the hopes that VA and Congress will utilize the findings to prepare for long-term care needs of the newest era of war veterans.

A new generation of young Americans is once again deployed around the world answering the Nation's call to arms. Unfortunately, without urgent changes in healthcare funding, new veterans will soon discover that their battles are not over. They will be forced to fight for the life of a healthcare system that was designed specifically for their unique needs.

The American Legion believes that the solution to the Veterans Health Administration's recurring financial difficulties will only be achieved when VA funding becomes mandatory. Under a mandatory funding, VA healthcare would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned healthcare benefits of enrolled veterans.

The Veterans Health Administration is now struggling to meet its requirement to provide timely access to care and the American Legion believes that healthcare rationing for veterans must end. It is time to guarantee healthcare funding for all veterans.

Mr. Chairman, this concludes my testimony. Again, thank you for giving the American Legion an opportunity to present its views on this important issue.

[The prepared statement of Ms. Middleton appears on p. 40.]

Mr. MICHAUD. Thank you very much.

Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, I want to thank you for this opportunity to present the views of the Disabled American Veterans on the present and future state of VA's long-term care programs.

I will try to cover as many items that DAV believes to be with regards to overarching issues that exist today that hold tremendous sway over the future of VA long-term care programs.

As with this Committee, the DAV is greatly concerned about the last published strategic plan for VA's long-term care which was prepared over 7 years ago. Whatever strategic planning VA has for the program, the DAV is also concerned that VA has not sought involvement, input or advice from veteran service organizations, unlike the 1999 strategic plan in which this community was directly involved.

The 1998 report of the Advisory Committee on the Future of VA Long-Term Care compelled this 1999 VA strategic plan. Sustaining this momentum, passage of Public Law 106–117, Veterans' Millennium Healthcare and Benefits Improvement Act, brought about some degree parity between long-term care and acute care. However, some bias remains within VA's medical benefits package that has translated down and between institutional and noninstitutional extended care.

By policy, noninstitutional services must be made available to all enrolled veterans in need of such care. But VA is required to provide institutional services only to a subset of these enrolled veterans.

Mr. Chairman, coupling this protocol with a tremendous pressure of limited resources requires VA to drive down the costs of care while increasing the number of veterans served. This produces a synergistic effect that puts long-term care at a disadvantage

against other services in VA's medical benefits package, and all the more so for the resource intensive institutional extended care service line.

It is without doubt that our concern remains about VA's obvious shift away from meeting its statutory mandate of maintaining nursing home capacity. This practice must be addressed considering VA's own projection of the growing gap between capacity and demand. As VA shifts more of its institutional care workload to State Veterans Homes, we applaud Congress for taking what we hope is a first step to provide equitable relief to State Veterans Homes.

What seems to be lost is what DAV believes, that long-term care is a fundamental part of the continuum of medical care. Further, while institutional care has been painted with a broad brush, it is most certainly still needed. As our colleagues from the State Veterans Homes have testified, particularly for veterans that VA has termed hard to place patients.

While VA has become highly efficient at converting its non-service-connected community nursing home placements to Medicaid status, it has established no formal tie to centers of Medicaid and Medicare services, or with the States to oversee that unwritten policy.

Also, with regards to institutional and home hospice, despite offering to purchase hospice, VA refers thousands of veterans from its own program to those of Medicare without acknowledging it is doing so.

Mr. Chairman, VA is the only public healthcare system that charges co-payments to hospice patients. The DAV recommends the fulfillment of Congress' original intent in Public Law 108–422 in exempting veterans from having to pay co-payments when they receive VA hospice care in any setting.

As a number of dying veterans have increased to a current average of 1,800 a day, it is unconscionable to use co-payments as a healthcare utilization tool on dying veterans. With regard to non-institutional care, the DAV believes growing its capacity is important to meet the swelling long-term care needs of aging veterans.

We applaud VA leadership in eliminating local restrictions that depress capacity and limit access to noninstitutional care. However, the reports we continue to receive about veterans not receiving the care they need for their service-connected conditions tells us more needs to be done, particularly in the funding level that VA requests or that which Congress provides.

In closing, Mr. Chairman, the DAV urges this Subcommittee to consider holding additional hearings in order for Congress and the public to gain fuller understanding of what needs to be done for our Nation's aging, sick and disabled veterans.

This concludes my statement and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 43.]

Mr. MICHAUD. Thank you very much, Mr. Atizado.

Mr. Cowell.

STATEMENT OF FRED COWELL

Mr. COWELL. Mr. Chairman and Members of the Subcommittee, the Paralyzed Veterans of American (PVA) is pleased to present its views concerning access to and the availability of quality long-term care service for our Nation's veterans.

In the interest of time, PVA's oral testimony is focused in two primary areas with brief mention of other important issues.

The long-term care needs of younger OIF/OEF Veterans. Mr. Chairman, PVA believes that age-appropriate VA noninstitutional and institutional long-term programming for younger OIF/OEF veterans must be a priority for VA and your Subcommittee. New VA noninstitutional and institutional long-term programs must come online and existing programs must be reengineered to meet the various needs of a younger veteran population.

VA's noninstitutional long-term care programs will be required to assist younger veterans with catastrophic disabilities who need a wide range of support services, such as personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services.

These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration grant and VA's adaptive housing and auto programs, so that they can leave institutional settings and go home as soon as possible.

VA's institutional nursing home care programs must change direction as well. Nursing home services created to meet the needs of aging veterans will not serve young veterans well. As pointed out in the Independent Budget, VA must make every effort to create an environment for younger veterans that recognizes they have different needs.

Younger, catastrophically injured veterans must be surrounded by forward-thinking administrators and staff that can adapt programs to youthful needs and interests. The entire nursing home culture must be changed for these individuals, not just modified.

For example, therapy programs, living units, meals, recreational programs and policy must be changed to accommodate younger veterans entering the VA long-term care system.

Veterans with spinal cord injury and disease. PVA is concerned that many veterans with spinal cord injury and disease are not receiving the specialized long-term care services they require. Today's VA Spinal Cord Injury and Disease (SCI/D) long-term care capacity cannot meet current or future demand for these specialized services. Waiting lists exist at the four designated SCI/D long-term care facilities. Geographic accessibility is a major problem because none of these facilities are located west of the Mississippi River.

VA's own Capital Asset Realignment for Enhanced Services (CARES) data for SCI/D long-term care reveals a looming gap in long-term care beds to meet future demand. VA data projects an SCI/D long-term care bed gap of 705 beds in 2012 and a larger bed gap of 1,358 beds for the year 2022.

Methods for closing the VA SCI/D long-term care bed gap and resolving the geographic service issue are part of the same problem for PVA.

VA's construction budget for 2008 includes plans for new 120-bed VA nursing homes to be located in Las Vegas, Nevada, and at the new medical center campus in Denver, Colorado. Also, VA has announced construction planning of a new 140-bed nursing home care unit in Des Moines, Iowa.

Mr. Chairman, PVA needs your support to ensure VA nursing home construction planning includes the percentage of beds at each new VA nursing home facility for veterans with SCI and D. PVA requests that Congress mandate that VA provide for a 15 percent bed set aside in each new VA nursing home construction project to serve veterans with SCI/D and other catastrophic disabilities.

A 15 percent bed allocation in new VA nursing home construction projects would be a good first step toward resolving and improving the VA SCI/D long-term care bed capacity problem.

Mr. Chairman, PVA's written statement includes important detailed information on other VA long-term care issues that we feel deserve your consideration, such as the nursing home capacity mandate, the State Veterans Home life safety issues, and waiting lists for noninstitutional long-term care services.

PVA supports the Congressional decision to require VA to develop a strategic plan for long-term care. However, for this new plan to become a success, it must be a living document that contains positive and achievable recommendations and provisions for accountability. PVA supports a strategic long-term care plan that monitors the quality, availability and the appropriate balance between noninstitutional and institutional long-term care programs.

VA's strategic plan will also enable Congress to make better informed decisions regarding the provision of adequate financial resources to support VA care. If done correctly, VA's strategic long-term care plan will assist VA's planning and monitoring efforts to ensure appropriate programming, systemwide availability and quality of services.

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

[The prepared statement of Mr. Cowell appears on p. 47.]

Mr. MICHAUD. Thank you very much.

I really enjoyed the testimony of this panel as well. My first question for each of you is have your organizations heard of any problems with veterans not getting access to a bed because of a shortage of beds?

Mr. COWELL. Well, our members have problems. There are waiting lists for the four designated SCI/D long-term care facilities, Mr. Chairman. Those facilities are located in Brockton, Massachusetts, Castle Point, New York, Hampton, Virginia, and the residential care facility at Hines, Illinois. It is our understanding that all four of those facilities have waiting lists for our members.

Also, because of the high acute needs of paralyzed veterans they are often shunned and denied access to both community nursing home facilities, VA nursing homes and in some cases State Veterans Homes. So we have an access problem.

Mr. MICHAUD. And do you know how long that waiting list is at each of the facilities?

Mr. COWELL. Well, I can't speak for each facility, but the most recent information we have at the Hampton facility, that could be

up to a year and it is kind of an attrition issue. They need a veteran either to leave the facility, or in some cases to die before a new bed becomes available.

Mr. MICHAUD. Okay. And the DAV, have you heard problems from your members?

Mr. ATIZADO. Yes, Mr. Chairman, sparingly. But our greater concern is from here on, what is happening with the capacity to provide institutional long-term care paid for or provided by VA at the current level. And recent trends really lead us to be greatly concerned about how this is going to fit into the demographic imperative of the aging population. That is really what we are concerned about.

Mr. MICHAUD. Okay. And the American Legion, have you heard of problems with your members accessing beds for long-term care?

Ms. MIDDLETON. Mr. Chairman, I haven't—I am not aware of any so far. However, I do know that I haven't had a chance to speak with the different departments to see whether or not they have had any situations. And I am sure that there have been instances that I am just not aware of at this point. But I can find out for you.

Mr. MICHAUD. Great. The next question is for all three of you. As we heard from the State Veterans Homes, when you look at the regulations, the VA has certain regulations and the CMS has certain regulations. From what we are told, the CMS has stronger regulations. How would the American Legion feel about adopting the CMS regulations if they are stronger?

Or while you are thinking about that, how about DAV?

Mr. ATIZADO. Mr. Chairman, I can't speak intelligently about CMS' standards with regards to the quality of care provided in institutional settings. But if the State Veterans Homes believes this to be true, then obviously if it fosters higher quality of care, then I believe DAV would support that.

Mr. MICHAUD. Okay. PVA.

Mr. COWELL. I am sure we echo his remarks, Mr. Chairman. Also, I am not just sure who accredits the States Veterans Homes. But accreditation of a long-term care facility is an important step. And if you are just talking about the operational guidelines that CMS would require, I think that is a positive step. But also accreditation is something that should be looked at if it doesn't currently happen.

Mr. MICHAUD. Okay. American Legion, have you—are you still thinking? Okay.

Ms. MIDDLETON. I would agree to agree with what they said, echo what they said also.

Mr. MICHAUD. Okay. Thank you.

My next question, Mr. Atizado, is in your statement you had mentioned about the co-payments for hospice care. And if you don't know, hopefully the VA will be able to give me the number, what is the total amount of money those co-payments bring in? Do you have any idea?

Mr. ATIZADO. I have a rough idea, Mr. Chairman. But it is rather dated, not more than a couple years. I think it is around $5,000 in collections.

Mr. MICHAUD. Five thousand?

Mr. ATIZADO. In collections.

Mr. MICHAUD. Five thousand dollars in collections?

Mr. ATIZADO. Yes, sir.

Mr. MICHAUD. Total? Okay. Also relating to that same issue, you had mentioned that some VA facilities have been aggressive in establishing end of life programs while others have lagged behind. Do you have a list of those who are lagging? Or could you provide the Committee——

Mr. ATIZADO. We are talking about hospice?

Mr. MICHAUD. Yes, hospice.

Mr. ATIZADO. I apologize. I don't have that off the top of my head. I can get that information for you though, sir. So if I could submit that for the record to you, I would greatly appreciate it.

[The information was subsequently provided by the U.S. Department of Veterans Affairs in materials requested during the hearing, which appear here.]

Mr. MICHAUD. Okay. Great. No problem. Thank you very much.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I just would like to thank the witnesses for their informative testimony and I don't have any questions. But thank you all for coming.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

I have a question for all three of you folks. You know, we have a lot of OEF and OIF veterans returning with catastrophic injuries that are going to require them to get care for the rest of their lives. And this generation is generally younger. They are computer literate. They have children and high standards for the type of care that they need, obviously.

At the same time, you have an aging population with very different needs. So from your perspectives, what goals do you think the VA should be working toward to provide extended care to this diverse group of vets?

Mr. COWELL. Well, sir, in our opinion at PVA—and we have done considerable thinking about this. As you know, many veterans that are returning from OEF and OIF that have been paralyzed, some are able to transition to noninstitutional home and community-based programs fairly well. And I think VA will obviously be doing a good job in trying to make sure that those programs fit the needs of a younger population.

It seems to me the greater challenge is how to carve out a niche in VA institutional programming, nursing home type care that is going to meet the needs of these individuals. I mean, as you stated and our testimony talks about institutional care is basically built around an aging veteran population and how to try to meet the needs of a younger veteran population and co-mix those two age groups is going to be a difficult challenge. And I am glad to hear that the Committee is thinking about that problem and I am sure VA as well.

We just think that they really need to enlighten their staff. I know VA has been doing a lot of work for culture change in the nursing home care program and I think they need to give added emphasis on the needs of younger veterans.

Mr. HARE. Thank you.

Mr. Atizado.

Mr. ATIZADO. Yes, sir. I want to echo my colleague's statement with regards to finding age appropriate settings for our younger, more severely injured soldiers. There is one thing that I think we can be thankful about with this new population, is that they are most likely going to have a support network, whereas aging or older, elder veterans have a higher rate of dependency and nobody there to assist them with that.

I would like to speak very briefly about—at least mention all inclusive and/or assisted living, which is probably a program—in fact, it was a pilot program in the Mill Bill and it had glowing remarks both for care and patient satisfaction. But for whatever reason, VA has decided to decline using those services. That might be also an avenue that we could look into as far as treating our newer veterans.

Mr. HARE. Ms. Middleton.

Ms. MIDDLETON. In addition to what they have said, I would think that it also would be important to—as the patients, the newer, the younger veterans are at the long-term care facilities, to see, ask them what they feel should be changed. Because their impression, their perception of their place in the facility is also important. So to ask them what kind of things they feel should be changed and how they can be more integrated with the things that are going on, what kind of needs they feel should be addressed would be important also.

Mr. HARE. Okay. Thank you very much.

I yield back.

Mr. MICHAUD. Thank you very much. Once again, I would like to thank the three panelists for your enlightening testimony today. I look forward to our continuing to work together as we look at what we can do to help our veterans as they access long-term care needs. So once again, I thank all three of you very much.

And while the third and final panel is coming forward, we have Patricia Vandenberg who is the Assistant Deputy Under Secretary for Policy and Planning from the Veterans Health Administration. And she is accompanied by Dr. James Burris who is the Chief Consultant for Geriatric and Extended Care for the VHA. So I want to welcome you hear today and look forward to hearing your testimony.

STATEMENT OF PATRICIA VANDENBERG, MHA, BSN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JAMES F. BURRIS, M.D., CHIEF CONSULTANT, GERIATRICS AND EXTENDED CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. VANDENBERG. Thank you, Mr. Chairman and Members of the Subcommittee. I am very pleased to be here today accompanied by Dr. Jim Burris, our Chief Consultant in Geriatrics and Extended Care.

Mr. Chairman, I want to begin by thanking you for your recognition in your opening comments regarding the role that VA plays in being a model in long-term care. My 40 years of experience in

healthcare, the majority of it in the private sector, have given me broad exposure to what is happening in the field of long-term care and I am very pleased with what we will talking about today in terms of VA's approach to long-term care.

Our philosophy is to provide patient-centered long-term care services in the least restrictive setting that is suitable for a veteran's medical condition and personal circumstances, and wherever possible in a home and community-based setting. Nursing home care should be reserved for situations in which the veteran can no longer be safely maintained in the home or community.

VA expects to meet the growing need for long-term care through such innovative services as Care Coordination and Home Telehealth. VA's Care Coordination involves the use of health informatics, telehealth and disease management technologies to enhance and extend existing care. Care Coordination enables appropriate veteran patients with chronic conditions such as diabetes and congestive heart failure to remain in their own homes and defers the need for institutional care for as long as possible. This technology enables us to deliver care to veterans living remotely from VA facilities, including those in rural communities.

Inevitably, veterans will require nursing home care and VA will continue to provide nursing home care for all veterans for whom such care is mandated by statute and who seek that care from us. VA will also continue to provide nursing home care for veterans with special needs, including those with spinal cord injury, ventilator dependence, or serious chronic mental illness.

Transforming the culture of care in nursing homes from the traditional medical model to a more home-like patient-centered model is an imperative and we are pursuing this very actively. Recently, VA has also begun to care for younger veterans who have sustained polytraumatic injuries during their service in Enduring Freedom and Iraqi Freedom. But I have to note that this is not the first time that we have cared for young veterans. We have a history of caring for them for a number of years.

While the number of these seriously disabled OIF/OEF veterans is relatively small, the complexity of care they require is higher and their personal and social needs do differ from those of older veterans. VA is moving to adapt its long-term care services to meet the needs of these veterans.

VA is taking steps, first, to recognize the generational differences of this population and to incorporate appropriate changes into our care routines. For example, in VA nursing homes, transforming the culture of care to make the living space more home-like and friendly is an imperative, as is having resources such as an Internet cafe computer games or age-appropriate music and food. Allowing for family, and especially children to visit or perhaps stay overnight is another example of the accommodation that we are already making to generational differences.

In addition to VA nursing homes, VA supports the State Veteran Home Program with the provision of grants for construction and renovation and through per diem payments. Moreover, VA provides oversight to these homes. VA has developed a system of on-site inspections to assure quality of care in State Veteran Homes, including the identification of life safety issues.

In compliance with Public Law 109–461, VA is currently in the process of developing regulations to implement the provisions of this law. VA takes great pride in our accomplishments thus far and looks forward to working with the members of this Subcommittee to continue the Department's tradition of providing high quality care to those who have helped defend our Nation around the world.

This completes my oral statement and I look forward to your questions.

[The prepared statement of Ms. Vandenberg appears on p. 52.]

Mr. MICHAUD. Thank you very much, Ms. Vandenberg. I really appreciate your coming here today. Actually, I have several questions that relate to a lot of the comments that were made from our previous two panels.

The first one is the co-payment for hospice. What is the total amount of revenue that the VA brings in for that co-payment?

Ms. VANDENBERG. I will have to defer to Dr. Burris on that topic.

Dr. BURRIS. Actually, I don't have a number. We will have to get back to you, sir, for the record.

[The following was subsequently received:]

Deliverable 1: What is the amount of revenue VA received from hospice co payment?

Response: VA tracks co-payment amounts for inpatient services and outpatient services collectively rather than by individual services, so it is difficult to determine the exact amount of revenue VA received from hospice co-payments. However, VA estimated a total of $343,542 in annual revenue ($183,180 for home hospice and $160,362 for inpatient hospice, calculated at FY2006 rates).

Mr. MICHAUD. Okay. The DAV commented about the end-of-life program at many VA facilities, and that some have been aggressively established. But there are some that have been lagging behind. Do you have any idea who is lagging behind?

Ms. VANDENBERG. I can't tell you that. We can certainly provide that information for the record. I think I can say with personal conviction that this is a facet of our care continuum that I have been very actively promoting with my colleagues and I think it is one that we believe deeply and philosophically. And so, what creates inertia in some environments to move in that direction is something that we continue to look at. But we will supply that information for the record.

[The following was subsequently received:]

Deliverable 2: Which VA facilities offer Hospice and End of Life Care? Which do not—why are they lagging?

Response: In FY2006, every VA facility offered some form of hospice and end of life care service, while a recent survey found that only one-fourth of other US hospitals had a palliative care program. The VA's Hospice and Palliative Care program has transformed much of the end of life care provided or purchased by VA which has resulted in the following:

a. In FY2006, of all veterans who died in a VA facility, 42 percent received prior consultation from a palliative care team (up from 30 percent in FY2003).
b. The number of palliative care consults in our VA hospitals more than doubled between FY2003 and FY2006 and surpassed 20,000 this past year.
c. The number of veterans receiving VA-paid home hospice care tripled between FY2003 and FY2005, and has increased another 30 percent in the past fiscal year (to an average daily census of 427 veterans for FY2006).

While this growth provides evidence of VA's leadership as a healthcare system in the provision of end of life care, we recognize there are some areas in which utilization of hospice and end of life services is absent or low. Often the low utilization appears to be related to regional and cultural variations in the desire for hospice services. Overall, Veterans Integrated Service Networks (VISNs) 1,2,3,12, and 19 report lower levels of VA-paid home hospice care than other VISNs. While a number of individual facilities report little or no VA-paid home hospice census such as the VA Medical Centers in Albany and Northport, New York; Chicago; Dallas; Nashville; Providence, RI; Salt Lake City; San Diego; and Shreveport, LA these facilities have active palliative care programs within their medical centers and make numerous referrals for hospice care in the community, though not at VA expense.

To promote and honor veterans' preferences for remaining in their homes at the end of life, VA has established minimum levels of VA-paid home hospice as a VISN Directors Performance Measure. Additionally, VA tracks both home hospice and inpatient palliative care activity and is working with VISNs and facilities to assure reliable access to quality end of life care in all settings at every VA facility. To promote reliable access the following national conferences are planned for this year:

a. A senior leadership conference of Network Directors on July 17th to develop action plans to disseminate "best practices" in end of life care
b. A national conference of acute care, home care and hospice/palliative care staff on integrating palliative care across VA will be held July 24th to 26th

Mr. MICHAUD. Since you feel so deeply about this and we heard a number earlier about the co-payments. You know, it is end of life and why would we be charging any veteran co-payments?

Ms. VANDENBERG. Sir, I think that is a very relevant question and one that I can take back and take under advisement.

[The following was subsequently received:]

Deliverable 3: Why does VA charge veterans a hospice co-payment?

Response: Public Law 106–117, the Veterans Millennium Healthcare and Benefits Act 1999, requires that non-service-connected veterans receiving extended care services from VA pay a co-payment to the United States. Inpatient and home hospice services are among the services subject to a mandatory co-payment, with the exception of hospice services provided in a nursing home.

Mr. MICHAUD. Okay. Thank you. We heard from the State Homes about VA regulations versus the CMS and that CMS is more stringent. Have you looked at this issue? And if CMS is more stringent, would you consider adopting the CMS regulations if appropriate?

Ms. VANDENBERG. Sir, I think our regulations are fairly consistent. Perhaps one difference in the application of the regulations is the way the survey process is conducted. And we will certainly take the comments that were made by our colleagues today under advisement in terms of the rigor of the survey process.

Mr. MICHAUD. And if you could provide the Committee with what the differences between the two, I would be really interested.

Ms. VANDENBERG. I would be happy to do a side by side comparison.

[The following was subsequently received:]

Deliverable 4: Side by Side comparison of Center Medicare Services (CMS) and VA regulations for State Homes—Which is more stringent—Why not adopt one?

Response: The CMS standards are a generic set of national standards that are required to be met for all nursing homes in the United States that are certified under Medicare and Medicaid. They are used to determine con-

tinued eligibility for reimbursement and to assure the public that a nursing home meets at least the minimum standards for quality of care.

Each State is required to apply these standards but may in fact add requirements that are more stringent. The standard that applies is whichever—State or national—is the most stringent. For example, CMS standards do not address a specific nurse staffing requirement. The CMS standard states that staffing must be adequate. On the other hand States specify nursing hours per patient day that range in some states from 2.0 hours per patient day to 3.35 hours per patient day.

VA standards are based on the CMS standards but because the reimbursement framework and some other requirements are VA specific, the VA standards also address VA specific requirements.

The following are similarities and significant areas of difference between the VA and CMS national standards:

Similarities: In general, the basic clinical standards are similar for both organizations. There are nuances regarding in how they are written. Both sets of standards, because they are essentially the same in regard to resident care, are equally stringent. Both organizations are currently updating their requirements for Life Safety and intend to deploy the 2006 standards.

Differences: Areas of clear differences are primarily in the responsibilities of the homes in regard to payment oversight and processes and other system related requirements that differentiate the payment sources and mechanisms. These are VA Per Diem requirements versus Medicare/Medicaid requirements; oversight responsibilities as they relate to the payers; and an occasional technical difference. These differences will be pointed out more specifically below where a standard is present in one system but not the other.

Standards Unique to VA

- Notification of the Office of Geriatrics and Extended Care regarding changes in SVH administration is required.
- Specification of the percentage of veterans that must occupy the SVH
- Requirements for management of a SVH by a contractor
- Credentialing and privileging of the Medical Director
- Monthly required submission to VA of a request for per diem payment
- Requirements for nursing home with 100 or more beds to have a qualified social worker
- Requirement for RN staffing 24 hours per day 7 days per week
- Nurse staffing requirement of 2.5 hours per patient day for all State homes
- Specific requirements for reporting and following up on sentinel events including conducting a root cause analysis
- Specific bed hold and transfer policy
- A set of comprehensive standards around the SVH recognition process for new construction and/or renovation
- Standards for withholding per diem

Standards Unique to CMS

- Definition of skilled nursing
- Requirement to inform residents about Medicare and Medicaid eligibility and responsibility for certain charges
- Instructions regarding public display of information about how to apply for Medicare or Medicaid benefits
- Notification of the amount of money in a resident's account for SSI limits
- Limitations on charges to personal funds for Medicare and Medicaid covered services
- Admission requirements and Medicare and Medicaid eligibility
- Prescriptive detail about requirements for activities programming
- Automated data processing and transmission requirements for the Minimum Data Set (MDS)
- Penalties for falsification of data
- Preadmission Screening for Mentally III and Individuals with Mental Retardation
- Requirements for influenza and pneumococcal vaccine
- Disclosure of ownership requirements

Summary and Conclusions:

Although the clinical standards are essentially the same, the standards regarding admission, payment, transmission of data, ownership, and Med-

icaid and Medicare requirements differ because of the significantly different payment mechanisms, requirements for recognition, and accountability.

Another important distinction between the two sets of standards is that the CMS standards are overarching but defer to individual States for definition in a number of areas including but not limited to nurse staffing, bed hold days, and follow up on sentinel events so that the most stringent standard would prevail.

Finally, an important variation in the CMS approach is the nature of the interpretive guidelines and the survey process itself. CMS' interpretive guidelines are more prescriptive and provide more specific guidance than VA's. The CMS survey process is very clearly defined including the application of survey findings to a grid that distinguishes serious findings and proposes a solution ranging from a mere recommendation to serious monetary penalties and sanctions until findings are improved. VA intends to rewrite its own interpretive guidelines to provide clearer and more precise guidance for application of the VA standards.

VA will continue to utilize the current VA standards for survey of SVH. The current approach allows for application of the VA standards from the VA perspective as a payer for services and allows for one standard approach for all State Veterans Homes. Adoption of the CMS standards would introduce State-to-State variation in standards that is undesirable for the VA's integrated healthcare system approach to care. Some State requirements could be less than what VA would consider acceptable. In addition, since only approximately 40 percent of State Veterans Homes are CMS certified, VA would still be required to maintain its own national standards for the remaining 60 percent.

Mr. MICHAUD. Yes. The other issue, and if you could provide for the Committee—I know there is a priority list when you look at the State Homes. I believe it is $250 million, I think, is the backlog for priority ones. Could you provide the Committee with the priority one projects out there and the cost, as well as how many priorities you have?

Ms. VANDENBERG. Dr. Burris, could you please respond to that?

Dr. BURRIS. Yes. There are seven priorities and the priority group one projects are those for which, as you have already heard, the States have committed their share of the funding, so that when VA is able to offer a grant, the State is able to proceed.

Mr. MICHAUD. Okay. Could you provide the Committee with the different priority lists that you have available?

Ms. VANDENBERG. Yes, sir. We will provide that for the record.

[The following was subsequently received:]

Deliverable 5: List of different priorities for SVS Program.

Response: Priority Group Definitions for the Priority List

Priority Group 1. An application from a State that has certified Sate matching funds for the project.

Priority Group 1—Subpriority 1. A project to remedy conditions at an existing facility that have been cited as threatening to the lives or safety of the residents.

Priority Group 1—Subpriority 2. An application from a State that has not previously applied for a grant under 38 U.S.C. 8131–8137. Great Need: If State has no State homes beds.

Priority Group 1—Subpriority 3. An application from a State that has a great need for the beds. Great Need: If State has an unmet need of 2,000 or more beds.

Priority Group 1—Subpriority 4. An application from a State for renovations not included in Subpriority 1 of Priority Group 1.

Priority Group 1—Subpriority 5. An application from a State that has a significant need for the beds.

Significant Need: If State has an unmet need of 1,000 to 1,999 beds.

Priority Group 1—Subpriority 6. An application for construction or acquisition of a nursing home or domiciliary from a State that has a limited need

for the beds that the State, in that application, proposes to establish. Limited Need: If State has an unmet need of 999 or fewer beds.

Priority Groups 2 through 7. Applications from a State that does not have certified State matching funds for the project. Ranked same as Priority Group 1

Priority Group 2—Subpriority 1. A project to remedy conditions at an existing facility that have been cited as threatening to the lives or safety of the residents.

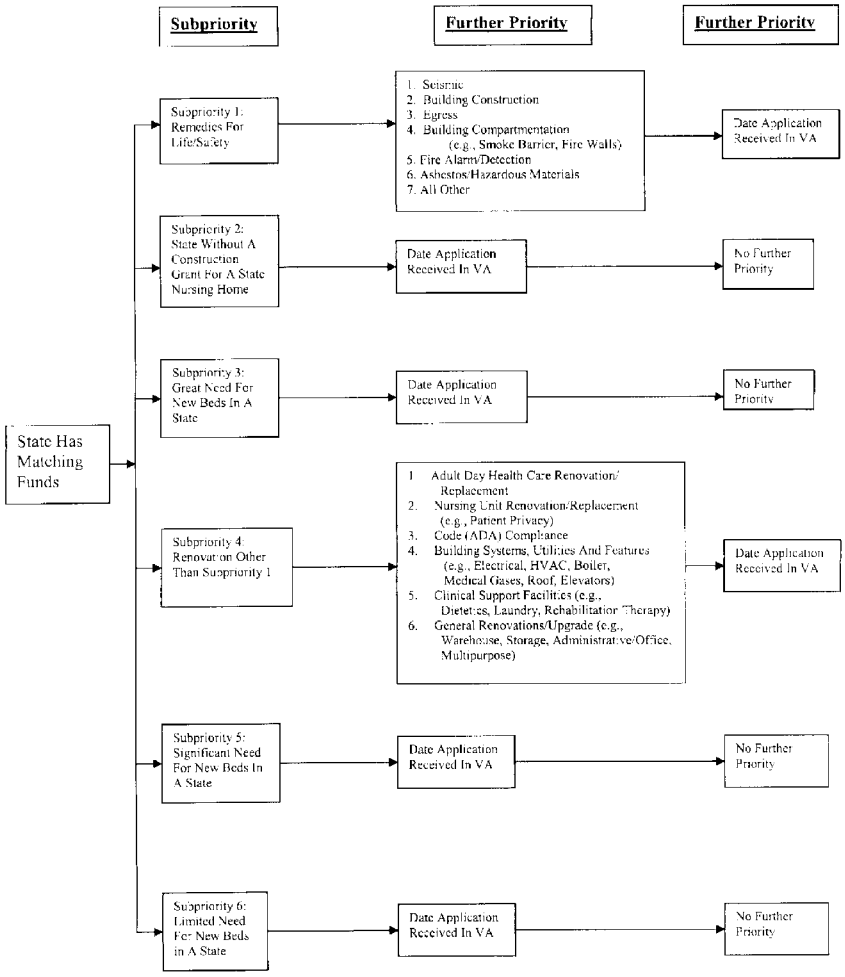
Priority Group 3—Subpriority 2. An application from a State that has not previously applied for a grant under 38 U.S.C. 8131–8137. Great Need: If State has no State homes beds.

Priority Group 4—Subpriority 3. An application from a State that has a great need for the beds. Great Need: If State has an unmet need of 2,000 or more beds.

Priority Group 5—Subpriority 4. An application from a State for renovations not included in Subpriority 1 of Priority Group 1.

Priority Group 6—Subpriority 5. An application for construction or acquisition of a nursing home or domiciliary from a State that has a significant need for the beds that the State, in that application, proposes to establish. Significant need if State has an unmet need of 1,000 to 1,999 beds. Priority Group 7—Subpriority 6. An application for construction or acquisition of a nursing home or domiciliary from a State that has a limited need for the beds that the State, in that application, proposes to establish. Limited Need: If State has an unmet need of 999 or fewer beds.

Example – Prioritization for Priority Group 1



Mr. MICHAUD. Okay. You have heard from the State Homes in Maine and I don't know if you had a chance to look at the testimony of Mr. Nagel, but in the back it showed a veterans complex that they are looking at doing in the State of Maine that has hospice and the State Home, and is a nice complex. Have you any initial thoughts on that concept, whether it is a good idea?

Ms. VANDENBERG. Well, I think when you look at the vision that we have in the VHA of providing patient-centered, integrated care, on the face of it, that concept makes a great deal of sense, that we would aggregate resources and have them be as patient-centered and as integrated as we possibly could.

I didn't have a chance to look at it from a policy standpoint prior to the hearing, but we will certainly review that.

Mr. MICHAUD. Okay. Great. We also heard from the previous panels concerning waiting lists, whether it is trying to get into the

VA system or a State veterans nursing home. How big of a waiting list is there for veterans who are trying to get into a home?

Ms. VANDENBERG. I would like to have Dr. Burris respond to that question.

Dr. BURRIS. As far as we are aware, there is no waiting list in the VA system for the category P–1–A veterans for whom nursing home care is mandatory. We don't maintain information about waiting lists in the State Homes. They really are owned, operated and managed by the States. But the State Veterans Home organization has surveyed their members and I believe the figure that was cited earlier in testimony was about 10,000.

Mr. MICHAUD. Okay. I don't know if you have microphones on or if you can pull it a little bit closer. If there is no waiting list, is there a surplus of beds? And if so, how many?

Dr. BURRIS. No, we don't feel there is a surplus. The average daily census of a little over 11,000 that we have currently represents the demand for both long-term residential care and for short-term care for post-acute care for patients who had had a stroke or an operation, a broken hip, a serious infection and need a period of restorative care or rehabilitation before they can be discharged back into the community.

Mr. MICHAUD. You heard from PVA earlier that there is a waiting list, in some cases a year, to try to get into—was it the four facilities?

Dr. BURRIS. Yes. That is something that VA has recognized and there are four new centers that are under development. But that is something that VA works very closely with PVA to monitor the demand for care.

Mr. MICHAUD. And when will the VA be able to eliminate that waiting list? Particularly when you look at what is happening with the war in Iraq and Afghanistan, I think we are going to see a higher need, unfortunately, in that particular area. So when is that waiting list going to be gone?

Dr. BURRIS. It is a little bit hard to predict. It is a moving target because there are new patients coming into the system all the time. I actually would have to defer to Dr. Margaret Hammond who directs that program for a definitive response.

Mr. MICHAUD. And could you provide us with what the waiting list is at each of those four facilities?

Dr. BURRIS. Yes, sir.

[The following was subsequently received:]

Deliverable 6:

a. What are the waiting times at the 4 SCI centers (PVA asserted it was up to a year)?

Response:

- Boston: 10 patients with waiting range from July 2005 to April 2007.
- Hampton: 12 patients with waiting range from September 2005 to March 2007.
- Castle Point: No wait list. Hines: 6 patients with waiting range from January 2007 to April 2007.

b. What is VA's timeline to eliminate the waiting list for the 4 SCI Centers?

Response: Implementation of the CARES Planning Initiatives will be used to increase geographic access to SCI LTC services. The timeline is dependent upon completion of the Tampa beds for which construction has begun,

and the implementation of LTC beds at Cleveland, Long Beach and Memphis which are in planning or design phases.

Access to non-institutionalized extended care services is being encouraged under the Uniform Benefits Package.

c. What is VA's estimate of the future need for inpatient beds for SCI patients (PVA cited CARES data projecting an SCI/D long-term care bed gap of 705 beds in 2021 and 1,358 beds in 2022)?

Response: The CARES spinal cord injury planning model for institutional care projected a demand for 1,388 available beds in FY2012 and for 1,575 beds in FY2022. Using existing workload data, the demand was met, in part, by SCI long term care center beds, by the average daily census of veterans with SCI in VA nursing home care units, in contract nursing homes, and other VA LTC settings. The model provided the basis for recommendations approved by the Secretary for 30 SCI LTC beds at Tampa, 20 at Memphis, 20 at Cleveland, and 30 at Long Beach.

Subsequently in 2004, VA was requested to revalidate the original 2001 SCI LTC planning model using a revised approach. This tentative model supported the original CARES recommendations to enhance access. This model projected a demand for 1,969 available beds in FY2012 and 2,622 beds in FY2022 for a 100 percent market share of veterans with SCI in priority group 1 a. Utilization data and inclusion of the CARES recommendations resulted in a projected gap of 705 as recently reported by PV A. Incorporating 2006 workload data of 154 SCI long term care beds, an average daily census of 905 in VA Nursing Home Care Unit, 293 in contract care, 42 in other VA LTC settings, and with full implementation of the CARES recommendations, there is a projected gap of 475 in FY 2012. Internal discussion and planning are needed to address this projected gap.

Mr. MICHAUD. And what would the VA estimate the future need will be, particularly when you look at what is happening with the war in Iraq and Afghanistan?

[The Priority List of Pending State Home Construction Grant Applications for FY 2007 appears on p. 60.]

My last question—I know I have run over time. But in the closing remarks of the DAV, they talked about the lack of a strategic plan that involves stakeholders input. It is discouraging to DAV and others in this community. I have always been one who will try to bring in—if you are trying to solve a problem, you bring in those who are really affected by it. Whether you agree or disagree, at least it gives you a broad perspective of what is going on.

What is VA doing to—when you look at these strategic plans, to bring in those who are going to be using the facilities?

Ms. VANDENBERG. I will refer to Dr. Burris who has had the lead in the formulation of the strategic plan.

Dr. BURRIS. Well, first of all, I would say that the long-term care strategic planning is part, really an integral part of the broader VA and VHA strategic planning. It is not a free-standing event. And so what we have done is to pull together the elements of those larger strategic plans, VA and VHA, that reflect long-term care needs and are developing a report for Congress as required by the law.

Public Law 109–461 provided really a very short turnaround time for this so that we haven't had a very extensive planning process as we did in the report that followed the Millennium Act. But we do consult with the stakeholders. The veterans service organizations, for example, are represented on our Geriatrics and Gerontology Advisory Committee, which is a Federal advisory Committee of folks external to VA. It meets twice a year. It just met last month here in Washington and we really had very extensive dis-

cussion with the Advisory Committee about where our long-term care programs are going.

We also consult regularly with the State Veterans Homes organizations, both the National Association of State Directors of Veterans Affairs and the National Association of State Veterans Homes. There is a liaison Committee that meets formally twice a year and we have informal communications throughout the year.

So we do make an effort to get input from stakeholders and those we collaborate with in providing care to veterans.

Mr. MICHAUD. Well, I would strongly encourage you to make sure that that input is taken in and taken seriously, because I feel—even though it might add a little extra time or energy, I feel very strongly that the more people you get involved in the process hearing their input, the better product that you will have in the end. And hopefully, it will definitely bring a lot more support for whatever programs that the VA brings forward to dealing with our veterans.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. I had a whole list of questions and you asked them all but one.

And again, I appreciate your taking the time to come this morning. Real time health information is critical to providing high quality healthcare. And the VA currently has the best electronic medical records available. Has there been any consideration given to sharing those electronic medical records with the State Veterans Homes? If not, could you tell me if that something that you might consider doing?

Ms. VANDENBERG. We have had extensive internal conversations regarding the parameters that we have to operate within in order to maintain patient privacy. And so the actual electronic medical record software is available in the public domain and we have talked to the State Veteran Home representatives about how we could collaborate with them using that tool. Direct interoperability does not seem to be legally feasible at this time given the parameters of the privacy laws that we operate under.

Mr. HARE. Okay. Thank you very much.

I yield back, Mr. Chairman. Thank you for this important hearing this morning.

Mr. MICHAUD. Thank you very much, Mr. Hare. And thank you for your advocacy for our veterans.

For those of you who don't know, Congressman Hare is a former staffer of the Ranking Member of this Committee for a number of years, Lane Evans. And he definitely has taken on where Mr. Evans has left off in dealing with veterans' issues.

Mr. Brown, unfortunately, had another commitment so he was unable to stay, but I would ask counsel if he has any questions.

Mr. TUCKER. Yes. I actually have a couple of questions. And it is always good to see a staffer do well there, Mr. Hare.

A question for Dr. Burris and a question for Ms. Vandenberg.

Dr. Burris, you state that the 11,000 average daily census which you are currently estimating for FY 2008 does not provide any surplus and it does not give you any problems with a waiting list. If 2,391 nursing home beds suddenly appeared across the country, would you be able to find veterans to fill those beds?

Dr. BURRIS. We might be able to find people to put in the beds, yes. One of the problems we were having, though, with the 13,391 requirement was that our medical centers were having trouble finding appropriate patients to admit to the nursing home, who met the eligibility requirements for that level of care. So I think we would have difficulty filling those beds, frankly.

Mr. TUCKER. And Ms. Vandenberg, VA spends approximately 90 percent of its long-term care budget on institutional care. For Medicaid, it is nearly 60 percent. Do you believe this differential is due to the unique qualities of the veterans' population, that you are going to always have to have more institutional care than noninstitutional care?

Ms. VANDENBERG. Well, I think that as was evidenced in some of the prior comments, what contributes to the cost in our facilities is a function of the complexity of the care that we are providing. And so when we look at the funds that are allocated for institutional care, that complexity is reflected in that. If the question underlying your question is are we devoting sufficient funds to promote the noninstitutional care, at this point in time we believe we are making steady progress in reaching our targets for noninstitutional care and we are constantly monitoring that. Does that respond to the question?

Mr. TUCKER. Yes. I think we are getting to a point where the VA needs to provide more home and community-based care and I think our concern up here is that those funds should not just be shifted from institutional care to noninstitutional programs, that we actually grow the home and community-based funding streams and programs, as well as maintain a capacity and a capability of providing nursing home care.

Ms. VANDENBERG. Thank you.

Mr. TUCKER. Okay. Thank you.

Mr. MICHAUD. Once again, I would like to thank this panel and the previous two panels for your coming here this morning. I enjoyed the testimony and look forward to working with all of you as we move forward dealing with this very important issue of long-term care for our veterans. So once again, thank you very much.

Ms. VANDENBERG. Thank you, sir.

Mr. MICHAUD. The hearing is adjourned.

[Whereupon, at 11:30 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud
Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

This morning, the Subcommittee on Health will examine the state of VA's long-term care programs and services.

In terms of demographics, the veteran population is aging and will require a greater amount of long-term care services. Out of a veteran population in this country of 25 million, nearly 45 percent are over the age of 65, and the number over the age of 85 is expected to reach 1.3 million by 2010.

In addition, the veteran population is poorer, sicker and older than their non-veteran counterparts.

The VA will also be facing an entirely new generation of veterans in need of long-term care services—some of our wounded returning OEF/OIF veterans, who have different needs than those of our older veterans.

Medicaid is the principal financer of long-term care. In 2004, Medicaid spent $90 billion on long-term care services, of which $57.6 billion, or 64 percent, was for institutional care.

The VA has requested $4.6 billion for long-term care services in FY 2008. Nearly 90 percent is for institutional care.

The VA must, in my view, maintain its nursing home capacity while vigorously expanding its non-institutional care capabilities.

Contrary to the plain evidence of an increasing long-term care demand, this year the VA will again ignore its clear legal responsibility to maintain its nursing home bed capacity. The VA's FY 2008 budget estimates a further drop in the average daily census to 11,000, nearly 20 percent below the required level.

I am concerned that VA is not doing enough to maintain its nursing home capacity, while not moving fast enough to provide more home and community-based care.

An integral component to VA's institutional care services is The State Veterans Home Program. Currently, State Veterans Homes handle over 50 percent of the VA's overall patient work load in nursing homes.

I believe we must maximize this existing resource as well as other resources within our communities to ensure the best possible care for our veterans.

The VA has a long history of providing long-term care services, and I believe that the VA has many lessons it can teach other areas of the Federal Government, and the private sector, on how best to provide these services. The VA can indeed be a long-term care model for others.

VA continues to have an obligation to meet the long-term care needs of our veterans. I look forward to hearing from our witnesses as to how VA should meet this obligation in the future.

Prepared Statement of Hon. Henry E. Brown, Jr.

Thank you Mr. Chairman for holding this hearing to examine how the Department of Veterans of Affairs is providing a mix of extended care services and how VA intends to address the provision of long term care in the future.

Today, one of the biggest challenges in both VA and the private sector healthcare systems is providing long-term care to a growing aging population. This challenge is amplified for VA, which must facilitate care for the special needs of our disabled and aging veterans. The Department is also facing an emerging new need to care for seriously injured younger veterans returning from the Global War on Terror.

I appreciate that at our hearing today we have witnesses representing the State Veterans Homes. On Veterans Day last year, I had the privilege of dedicating a new State Veterans Home in Walterboro, South Carolina. This 220 bed facility, the Vet-

erans' Victory House, is one of the most modern of its kind in the United States, and includes a 52 bed secured dementia unit.

In partnership with the VA, State veterans' homes can help provide a broad range of services to meet the long-term care needs of our veterans. Last year, with the enactment of Public Law 109–461, the Veterans Benefits, Healthcare, and Information Technology Act of 2006, Congress expanded the authorities for State veterans' homes. The law requires VA to reimburse State veterans' homes for the full cost of care for a veteran with a 70 percent or greater service-connected disability rating and in need of care for service-connected conditions. It also ensures that veterans with a 50 percent or greater service-connected disability receive, at no cost, medications they need through VA.

Additionally, Public Law 109–461, requires VA to publish a strategic plan for long-term care. Hopefully, this plan that has been a long time in coming will provide a clear map of the Department's future plans for delivering long term care for those veterans who rely on VA to provide these services. I look forward to the delivery of this plan as required by law. We have allowed VA to drag its feet on this issue for far too long.

Mr. Chairman, we need to remember that the quality in which we provide long-term care is a reflection on how this country honors the sacrifices of our Nation's veterans.

I look forward to our discussion today and to explore innovative steps we can take to provide the best patient-centered care to enhance the quality of life of veterans in need of long-term care services. Knowing what a busy day today is, I yield back

---

Prepared Statement of Raymond A. Nagel, Chief Executive Officer
Main Veterans' Homes, Augusta, ME

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on behalf of the Maine Veterans' Homes ("MVH") on the topic of "The State of VA's Long-Term Care Program: Present and Future," including the important issue of access by rural veterans to quality long-term nursing care.

I am the Chief Executive Officer of MVH. I have 23 years of healthcare management experience including 19 years of experience as a Medical Services Officer within the United States Army and the United States Army Reserves. I am a combat veteran of Operations Desert Shield and Desert Storm. I recently retired from the U.S. Army Reserves as a Lieutenant Colonel and commander of a 296-bed Combat Support Hospital. I have been the chief executive officer of the Maine Veterans' Homes for nearly 1 year.

MVH is a public body corporate created by the State of Maine to provide long-term nursing care to Maine veterans. MVH operates six long-term nursing care facilities for veterans at Augusta, Bangor, Caribou, Machias, Scarborough, and South Paris. In the aggregate, MVH currently operates 640 skilled nursing, long-term nursing, and domiciliary beds for Maine veterans. This makes MVH one of the largest systems of long-term nursing facilities in the State of Maine, and we are very proud of the quality long-term care nursing services that we provide to Maine veterans.

Also, as one of the largest and most successful State Veterans Homes systems in the nation, MVH provides a crucial portion of the healthcare continuum for Maine veterans. Our facilities are each relatively small in size, 30 to 150 beds each, and this allows them to be located not only at one or two locations, but throughout the State of Maine, allowing greater ease of access to our facilities by veterans living in the most rural parts of Maine. In the future, we hope to develop additional inpatient and out-patient services at all of our six locations in order to offer rural Maine veterans greater access to all of the services that the Maine Veterans' Homes, the Maine Bureau of Veterans Services, and the United States Department of Veterans Affairs ("VA") provide.

MVH is part of a national system of State Veterans Homes. The State Veterans Homes system is the largest provider of long-term care to our Nation's veterans. There are 126 veterans homes in all 50 States and the Commonwealth of Puerto Rico. Nursing home care is provided in 121 homes, domiciliary care in 53 homes, and hospital care in 5 homes. These homes presently provide over28,000 resident beds for veterans of which almost 22,000 are nursing home beds. These beds represent about 50 percent of the long-term care workload for the VA.

The State Veterans Homes play an irreplaceable role in assuring that eligible veterans receive the benefits, services, and quality long-term healthcare that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate

the Veterans' Affairs 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 consistent support of the Veterans' Affairs Committee, working with the Appropriations Committee, to ensure that per diem payments by the VA will continue under current eligibility criteria.

The Maine Veterans' Homes is a leader in the national system of State Veterans Homes and a leader in the National Association of State Veterans Homes ("NASVH"). The membership of NASVH consists of the administrators and staff of State-operated veterans homes throughout the United States. 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 healthcare of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meet orexceed 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 needing long-term care, several States established veterans homes to care for those who had served in the military.

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

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 assure that these standards are met and to assure the proper disbursement of funds. Together, the VA and the State Veterans Homes represent a very effective and financially efficient Federal-State partnership in the service of our Nations veterans.

VA per diem payments to State Homes are authorized by 38 U.S.C. § 1741–1743. The per diem payments are intended by Congress to assist the States in providing for the 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 $67.71 per day for nursing home care, $40.48 per day for adult day healthcare, and $30.31 per day for domiciliary care. Our State Veterans Homes cannot operate without receipt of per diem payments from the VA under current eligibility criteria.

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 assure 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 in response to the increasing number of elderly veterans who require long-term healthcare. In fact, as a nation we face the largest aging veterans population in our history. By the end of this decade, the number of veterans aged 85 and older will have tripled from 422,000 to 1.3 million. If the State Veterans Homes program is to fill the need for additional long-term care beds required in certain States and to respond to the increase in the number of veterans eligible for long-term care nationally, it is critical that the State Veterans Home construction grant program be sustained at adequate levels.

The State Veterans Home program now provides about 50 percent of the VA's total long-term care workload. The VA has estimated that nursing care beds in the State Veterans Homes nationwide are 87 percent occupied. The beds at our homes in Maine are approximately 96 percent occupied. Many of the State Veterans Homes nationally 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 less than $68 per day, well below the cost of care in a VA nursing home, which is over $560 per day.

Although there are no national admission requirements for the State Veterans Homes, there are State-by-State medical requirements for admission to such homes. Generally, a State will require a medical certification confirming several significant deficits in activities of daily living (an assessment of basic living functions) that together 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. Veterans qualifying for long-term nursing care at a State Veterans Home are almost always very ill and elderly, and many are afflicted with mental health conditions.

State Veterans Homes as a VA Resource

The Veterans' Millennium Healthcare Act ("Mill Bill"), Pub. L. No. 106–117, enacted significant changes to veterans' long-term healthcare. 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 that is integrated much more fully with the VA's own long-term care program.

The State Veterans Homes 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 a very cost-effective 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, while paying the lowest available per capita cost for each eligible veteran. Including State Veterans Homes nursing beds in the mandated VA long-term care totals would allow the VA to meet its legislative mandate, shift some of its long-term care services to the State Veterans Homes, and ultimately increase the capacity of the VA to provide greater short-stay, highly specialized, post-acute rehabilitative care.

This goal can be accomplished by the State Veterans Homes at substantially less cost to taxpayers than other alternatives. 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 $563.45 per day. The cost of care to the VA for the placement of a veteran at a contract nursing home, which is not required to meet more stringent State Veterans Home standards, is approximately $225.30 per day. The same daily cost to the VA to provide quality long-term nursing care at a State Veterans Home is far less—only $67.71 per day.

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.

Innovative Programs at the State Veterans Homes

Although several states have either a "great" or "significant" need, as defined by Federal law, to build new State Veterans Homes immediately, the State of Maine, with 640 beds already in successful operation, has built all of the long-term care beds for veterans that we expect to build. We are limited by Federal law to the 640 long-term care beds for veterans that we currently operate. Furthermore, the State of Maine operates our long-term care beds for veterans at over 96 percent of capacity, and this is virtually full occupancy, since veterans continually are admitted to or discharged from the homes.

If the State of Maine is to provide greater levels of services to its veterans, MVH must expand the types of services we offer to Maine veterans. Therefore, MVH has initiated an ambitious new program to expand the delivery of additional health-care related services at locations clustered around its existing State Veterans Homes.

For example, at the 150-bed MVH nursing and domiciliary facility located at Bangor, Maine, MVH is proposing to construct an integrated "veterans campus" containing an 18,500 square foot Community Based Outreach Clinic ("CBOC"), a seven-bed hospice facility, and an 18-unit elderly veterans housing facility. Attached to my testimony are proposed site plans for this veterans' campus. The CBOC (to be oper-

ated by the VA) will provide primary healthcare to Maine veterans and house State offices providing veterans services. The hospice (to be operated by MVH) will provide critically needed end-of-life and palliative care services to Maine veterans. Finally, the elderly housing facility will provide short and long-term housing to Maine veterans who may be using the other health-related services provided at the veterans' campus.

This veterans' campus can be constructed using solely the financial resources of MVH, and at no cost to Maine taxpayers. Later, if appropriate, the services provided at such a veterans campus could be expanded to include assisted living and congregate housing, adult daycare services, and home healthcare services for veterans. In this manner, MVH will provide, within an integrated setting, comprehensive healthcare services to Maine veterans covering the full continuum of care. Furthermore, this concept could be replicated at the sites of each of the other five existing MVH facilities, in order to provide veterans throughout the State of Maine with easy access to comprehensive healthcare in both urban and rural settings. Attached to my testimony is a map of the State of Maine showing the locations of all six existing MVH facilities. This concept, if successful in Maine, can be replicated elsewhere in the country.

Conclusion

Mr. Chairman and Members of the Subcommittee, thank you for your commitment to quality long-term care for veterans and for your support of the State Veterans Home system as a central component of that care. We believe that the State Veterans Homes can play a much more substantial role in meeting the long-term care needs of veterans. MVH recognizes and supports the national trend toward deinstitutionalization of healthcare and the provision of long-term healthcare in the most independent and cost-effective setting. We have previously proposed to the VA that we explore together creative ways to provide a complete and conveniently located continuum of healthcare to our veterans, both rural and urban, at State Veterans Home-sponsored facilities 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 long-term healthcare solutions and for more closely integrating the State Veterans Home program into the VA's overall healthcare system for veterans.

Prepared Statement of R. Roy Griffith, Chairman, Liaison Committee National Association of State Veterans Homes, and Administrator, Oklahoma Veterans Center, Talihina, OK

Chairman Michaud, Ranking Member Miller, Members of the Subcommittee:

I want to commend you for holding today's hearing and thank you very much for inviting the National Association of State Veterans Homes (NASVH) to testify on the role of State Homes in the provision of long term care to our Nation's veterans. I especially want to thank you for allowing me to substitute for our national Legislative Chair, Bob Shaw, who was unable to make it to today's hearing due to the recent death of his mother.

This morning I am speaking as a member of NASVH's Executive Committee and Chairman of our VA Liaison Committee, where I am responsible for interfacing with the Department of Veterans Affairs. In addition, I am here as the Administrator of the Oklahoma Veterans Center in Talihina, Oklahoma, which provides long term care for 175 veterans, including a 48 bed wing for ambulatory Alzheimer's patients.

Mr. Chairman, the State Home program dates back to the post-Civil War era when several States established homes in which to provide shelter and care to otherwise homeless, sick and maimed Union soldiers and sailors. In 1888 Congress first authorized Federal grants-in-aid to the States that maintained these homes, including a per diem allowance for each veteran of twenty-seven cents ($100 per year per veteran). Over the years since that time, the State Home program has been expanded and refined to reflect the improvements in standards of medical practice, including the advent of nursing home, domiciliary, adult day health, and other specialized geriatric care for veterans.

For example, as I mentioned, the facility that I manage in Talihina has a 30-bed secure unit for Alzheimer's patients, a growing need in this veterans' population. At least two State Homes are providing adult day healthcare, and a number of others are developing programs or plans for this discipline and other emerging approaches to delivering care in less restrictive settings. In fact we are presently working with VA and State officials in a task force established by Deputy VA Secretary Gordon

Mansfield to examine ways to establish more veterans adult day healthcare programs through auspices of the States and their State Veterans Homes.

Mr. Chairman, with the aging of our "baby boomer" generation, America faces a looming long term care crisis, one that many of our Nation's veterans are already facing. Although the veteran population is declining, their needs are still rising. VA projects that today's veteran population of 24.5 million will continue to decline through 2020, but that the number of veterans over 65 years of age will rise and ultimately peak in the year 2014, driven by the very large number of Vietnam veterans. Most alarming, the number of veterans over the age of 85 is projected to increase by 173 percent by 2020, creating an ever greater number of veterans seeking long term care services.

Another important factor to consider is that we are seeing extraordinarily disabled veterans coming home from Iraq and Afghanistan with levels of injury and disability unheard of in past wars. Our incredible military medical triage and its applied technology has saved them, and many of them are now in VA polytrauma centers, but they present a medical and social challenge the likes of which we have never seen before. We are grateful that the numbers of these polytraumatic" injured are relatively small, but we must be cognizant that they will need extraordinary care and shelter for the remainder of their lives. While VA is doing an excellent job to address their immediate needs, neither VA nor these veterans' families are fully prepared today to deal with their longer term needs. I am hopeful that our partnership with VA might be a basis for the State Veterans Homes to play a small but vital role in aiding these catastrophically injured veterans by providing them a home-like atmosphere, a caring environment and the level of clinical services they are going to need for the remainder of their lives.

Finally, the newest generation of veterans, from the Persian gulf war until today, exhibits different expectations than their counterparts of the past. In general they are computer literate, well educated, want more involvement in their own care and want to control their own destinies. As these veterans age into later life and begin to need long-term care services, this will make VA's and our jobs much more challenging.

Mr. Chairman, today State Homes provide the bulk of long term care for our Nation's veterans. Last year GAO reported that State Homes provide more than 50 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long term care budget. And the trend over recent years shows that State Homes are increasing their share of workload while their share of VA's budget continues to decline. VA pays just $67.71 as a per diem payment for each veteran residing in a State Home, which is less than one-third of the average cost of that veteran's care. The remaining two-thirds is made up from a mix of funding, including State support, Medicaid, and other public and private sources.

Compare this to VA's cost when contracting out with community nursing homes where VA covers 100 percent of the cost of care, often upward of $200 per day, or when VA provides the care through one of its own nursing homes, where the average cost of care is in excess of $400 per day.

In addition to this per diem support, VA also helps cover the cost of construction, rehabilitation, and repair of State Veterans Homes on a matching basis with States. VA will provide up to 65 percent of the cost with the State providing at least 35 percent of the project's costs. The program was refined in 1999 under the Veterans Millennium Healthcare and Benefits Act, which created a series of priority categories for pending construction projects. At the top of the priority list are life and safety projects, and new home construction in States without any State Home beds.

Unfortunately, in FY 2006, the construction grant program was cut from $104.3 million down to $85 million after a decade of stable funding marked by modest Consumer Price Index-type increases. In FY 2007 the administration proposed and succeeded in holding down this funding at the reduced level of $85 million, continuing the $20 million reduction below the established 2005 baseline. The total funding reduction over 2 years is approximately $40 million.

As a result of these real-dollar reductions, as well as the effects of inflation and rapidly rising construction costs, the backlog of State Home construction projects is rapidly rising. There are currently $242 million in pending "priority 1" State Home projects, and NASVH estimates that the total backlog of all potential qualifying State Home projects, including new and replacement bed and new home proposals in Texas, North Carolina, North Dakota, California, Florida and other States, could soon surpass $1 billion.

Last month, NASVH testified before the Appropriations Subcommittee and requested that funding for the State Home construction grant program be increased to at least $160 million in FY 2008 in order to reduce the rising backlog, address the most serious life and safety issues, and protect the State Home system for the

future. We would be grateful for any support you and this Committee can offer in that regard.

I believe it is important to note for the Subcommittee that, since the Civil War, States have assumed the burden of care for veterans and today spend over $3 billion annually to provide this care, despite the fact that veterans of our armed forces are serving the whole nation, not just their States. Seen this way, the care rendered to veterans by the States actually constitutes a subsidy to the Federal Government, even though the rhetoric you may hear makes the opposite argument—that VA subsidizes the States. In fact, if the States were to choose to abandon the State Home program, the burden of care for these veterans would revert to the Federal Government, either through the VA directly, or to Medicare and Medicaid.

Finally, Mr. Chairman, like all healthcare facilities, State Homes are not immune from human errors and operational problems, such those recently reported in Arizona and Minnesota When such problems are discovered, they must not only be aggressively investigated and corrected, but the State Home has an obligation to take additional measures to ensure that such problems do not recur. As a system, however, NASVH is quite proud of the record of State Homes in providing quality care. One reason for this record is the extremely tough regulatory and oversight controls placed on State Homes—by both Federal and State agencies.

Most State Veterans Homes are part of a State's departments of veterans' affairs, public health, or other State agency. Some Homes operate under the governance of a Board of trustees, a Board of Visitors, or other body made up of prominent citizens, retired senior military personnel, former state and Federal public officials and veterans. In addition, State financial and management agencies and offices will often perform extensive audits of State Homes every two to 3 years.

Each State is responsible for ensuring veterans receive quality long term and healthcare services and achieve high patient satisfaction, safe environmental conditions, and sound financial management. The primary responsibility resides in the State agency or office that manages State Homes, although other State agencies may share some oversight responsibilities, such as for finances. State Homes that are overseen by Boards also face direct scrutiny from their appointed Board Members. As State-owned public buildings, State Homes are subject to State and local fire marshal and life-safety inspections on a routine basis to examine for fire hazards and life-safety issues.

In addition, the Department of Veterans Affairs holds State Homes to the same high standards as are applied to nursing homes that VA owns and operates. State Homes are inspected annually by teams of VA examiners, including physicians, nurses, social workers, dieticians, activity specialists and mechanical and structural engineers. These visits typically consume a week, with more time involved for resolving any issues VA's examiners identify. VA's Inspector General also audits and inspects State Homes whenever and wherever it is determined necessary.

In addition, States Homes authorized to receive Medicaid and Medicare reimbursement are subject to unannounced inspections by the Centers for Medicare and Medicaid Services (CMS), usually consuming three or more workdays, and staffed by a variety of long term care experts. State Homes are also subject to announced and unannounced inspections by HHS's Inspector General. Furthermore, the Department of Justice's Civil Rights Division is fully authorized to conduct investigations and takes necessary legal action to correct any complaints of neglect or abuse found to exist at State-run nursing homes. Finally, in some State Homes national veterans service organizations (VSOs), such as The American Legion, will regularly inspect State Homes, looking at both operational and management issues.

Mr. Chairman, State Veterans Home provide safe, high-quality and affordable care to our Nation's veterans. This successful Federal-State partnership is an indispensable component of our nation's long term care resources, and we are grateful for your continued support. Millions of American veterans are going to need long-term care in the years ahead and the State Veterans Home system must continue to be an important component of the solution.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions you may have.

Prepared Statement of Shannon L. Middleton, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on VA's strategic direction and plans to address the aging veteran population and the needs of the recently separated veterans.

AGING VETERAN POPULATION

A July 1984 study, Caring for the Older Veteran, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VETPOP 2001 Adjusted, show there were 25.6 million veterans in 2002 and 9.76 million, or 37 percent, are aged 65 or older. According to the 2003 National Survey of Veteran Enrollees' Health and Reliance on VA, 14 percent of the veteran population was under the age of 45, 39 percent were between the ages of 45 and 64, and 47 percent of veterans were 65 years or older. Compared to the 2001 Survey, in which age distribution was 21, 41 and 39 percent respectively, it is clear that the "demographic imperative" predicted in 1984 is now upon us.

The study cited an "imminent need to provide a coherent and comprehensive approach to long-term care for veterans." Twenty-three years hence, the coherent and comprehensive approach called for has yet to materialize. The American Legion supports a requirement to mandate that VA publish a comprehensive Long Term Care Strategic Plan.

The Veterans Millennium Healthcare and Benefits Act 1999 provided VA the authority to act on these projections. Based on an "aging in place" continuum of care model, VA was mandated to begin providing a variety of non-institutional services to aging veterans, including; home-based primary care, contract home healthcare, adult day healthcare, homemaker and home health aides, respite care, telehealth and geriatric evaluation and management.

On March 29, 2002, the government Accountability Office issued a report that stated that nearly 2 years after the Millennium Acts passage, VA had not implemented its response to the requirements that all eligible veterans be offered adult day healthcare, respite care and geriatric evaluation. At the time of GAO's inquiry, access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an Average Daily Census of 68,238) in non-institutional settings, VA only spent 8 percent of its LTC budget on these services. Additionally, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day healthcare in non-institutional settings.

By May 22, 2003, over 1 year later, GAO testified before this Subcommittee that things had not improved and that veterans' access to non-institutional LTC was still limited by service gaps and facility restrictions. GAO's assessment showed that for four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. GAO summarized the problem nicely when it testified that "[f]aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

In the area of nursing home care, VA is equally recalcitrant in implementing the mandates of the Millennium Act. The Act required VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001, 11,969 in 2002 and 12,339 beds in 2003. VHA estimates it had 11,000 beds in 2004 and projected only 8,500 beds for fiscal year 2005. The American Legion believes that VA should be required to restore its nursing home care unit capacity as intended by Congress to the 1998 level. Additionally, VA should be prohibited from counting any but their own nursing home care unit beds for the purpose of compliance with the provisions of the Millennium Act.

VA claims that it cannot maintain both the mandated bed capacity and implement all the requirements of the Millennium Act. Providing adequate inpatient LTC capacity is good policy and good medicine**.** The American Legion opposes attempts to repeal 38 U.S.C. • 1710B(b).The American Legion believes VA should provide the quality of care mandated by Congress for the long term care of America's veterans. Congress should provide adequate funding to VA to implement its mandates.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious; for fiscal year 2004 VA paid a per diem

of $59.48 for each veteran it places in SVHs, compared to the $354.00 VA said it cost in FY 2002 to maintain a veteran for 1 day in its own NHCUs.

Currently, VA is authorized to make payments to states for 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. Grants for construction of state extended care facilities provide funding for 65 percent of the total cost of building new veterans' homes. Recognizing the growing long-term healthcare needs of older veterans, it is essential that the State Veterans' Home Program be maintained as a viable and important alternative healthcare provider to the VA system. State authorizing legislation has been enacted and state funds have been committed. The West Los Angeles State Veterans' Home, alone, is a $125 million project. Delaying this and other projects will result in cost overruns from increasing building materials costs and may lead states to cancel these much-needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes. The American Legion also supports providing prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients, along with the payment of authorized per diem to State Veterans' Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans' Home.

COMMISSION ON THE FUTURE FOR AMERICAN'S VETERANS

In testimony delivered in 2006 addressing VA Long Term Care, GAO identified a major challenge in VA's ability to plan for nursing home care as estimating which veterans will seek care from VA and what their nursing home needs will be. The unpredictability of the long term care needs of those suffering from polytrauma, blast injuries and lasting mental health conditions as a result of participation in the ongoing Global War on Terror will no doubt make planning even more challenging.

The Commission on the Future for America's Veterans was established in September 2006. The Commission's purpose is to ascertain the needs of veterans 20 years in the future. The Commissioners are experts on veterans' issues and include Past National Commanders of the largest veterans service organizations, those who have treated combat veterans, as well as a former VA administrator and a former Congressman. The Commission was created by the Veterans Coalition, which includes The American Legion, Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), AMVETS, Vietnam Veterans of America, Blinded American Veterans, Jewish War Veterans, and Military Order of the Purple Heart

The Commission has been conducting townhall meetings around the country to allow veterans, family members and caregivers an opportunity to express their views on the future needs of servicemembers, especially those who have been injured in the current Global War on Terror. At the conclusion of this fact finding initiative, the Commission will create a report that will include recommendations for addressing the needs identified. The Commission plans to deliver recommendations to the President, Congress, and the American public by Memorial Day 2008.

The American Legion supports this timely and proactive endeavor and hopes VA and Congress utilize the findings to prepare for the long-term needs of the newest era of war veterans.

MANDATORY FUNDING FOR VETERANS HEALTH CARE

A new generation of young Americans is once again deployed around the world, answering the nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom, liberty and security of us all. Also, like those who fought before them, today's veterans deserve the due respect of a grateful nation when they return home.

Unfortunately, without urgent changes in healthcare funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a healthcare system that was designed specifically for their unique needs. The American Legion believes that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when VA funding becomes mandatory. Funding for VA healthcare currently falls under discretionary spending within the Federal budget. VA's healthcare budget competes with other agencies and programs for Federal dollars each year. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

Under mandatory funding, VA healthcare would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned healthcare benefits of enrolled veterans.

The Veterans Health Administration is now struggling to meet its requirement to provide timely access to healthcare with funding methods that were developed in the 19th century. The American Legion believes that healthcare rationing for veterans must end. It is time to guarantee healthcare funding for all veterans.

Mr. Chairman, that concludes my testimony.

Prepared Statement of Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the Subcommittee our views on the present and future state of long-term care programs in the Department of Veterans Affairs (VA). Mr. Chairman, as you know, DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents, and survivors. For the past eight decades, the DAV has devoted itself to a single purpose: building better lives for our Nation's disabled veterans and their families.

The DAV is cognizant of VA's need to plan strategically how best to use its resources to provide equitable access for veterans needing acute care services, while also providing a growing elderly veteran population with institutional and non-institutional long-term care services. However, the present state of VA's long-term care program is now lagging behind its rich history as an early leader in caring for aging veterans, and is in danger of falling behind non-VA healthcare systems. We are concerned that the last published strategic plan for long-term care was prepared over 7 years ago. That strategic plan was intended to implement a number of recommendations from a 1998 report of VA's Federal Advisory Committee On the Future of VA Long-Term Care, entitled *VA Long-Term Care At the Crossroads.* This *Crossroads* report took a critical look at VA's long-term care program and highlighted the growing gulf between VA and non-VA long-term care systems. To address this disparity the report recommended swift and definitive action for VA to *"... retain its core of VA-operated long-term care services while improving access and efficiency of operations. Most new demand for care should be met through non-institutional services, contracting, and where available, State Veterans Homes."* In 1999 a number of the *Crossroads* recommendations to expand and enhance VA's long-term care programs were incorporated in Public Law 106–117, the Veterans Millennium Healthcare and Benefits Act, but much of the promise of the Millennium Act remains unfulfilled.

The number of service-connected disabled veterans rated 70 percent or higher for whom VA is required to provide extended care services has been increasing every year and experienced the highest growth from fiscal year 1999 through 2005. Accordingly, the delegates to the 2006 DAV National Convention, held in Chicago, Illinois, once again approved a resolution calling for the expansion of a comprehensive program of long-term care services for service-connected disabled veterans, regardless of their percentages of disability ratings.

Many elderly and infirm veterans, particularly those with service-connected disabilities, use the VA for their healthcare needs in post-acute and long-term care settings. Today, nearly 45 percent of the over 24 million veterans and nearly 50 percent of the almost 8 million veterans enrolled in VA healthcare are over the age of 65. The number of veterans over age 85 is expected to reach 1.3 million by 2011. In addition, the majority of VA enrollees plan to use VA as their primary source of healthcare. Given these projections, the wave of aging veterans will become a geriatric imperative with which VA will likely see a steadily rising and significant demand for long-term care services in the near future.

We are appreciative that in section 206 of P.L. 109–461 Congress required VA to develop a new strategic long-term care plan; however, we are concerned about the limited time the Act afforded VA in preparing such a critical plan. Furthermore, a March 20, 2006, report by the VA Office of Inspector General indicated VA is developing a Capital Asset Realignment for Enhanced Services (CARES) based strategic plan to address nursing home infrastructure inequities and realignments; however, the DAV is concerned that VA has not sought involvement, input or advice from veterans service organizations with any of these initiatives, unlike the 1999 VA strategic plan for long-term care in which this community was directly involved.

VA's long-term care program received significant modification with the passage of Public Law 106–117, which brought some degree of parity between long-term care, which was considered discretionary care, and acute care, which was considered "mandatory;" however, some tension remains. Furthermore, this tension has translated down and between institutional and non-institutional extended care, where VA is required to provide non-institutional services to all enrolled veterans in need of such care but only requires VA to provide institutional services to a subset of enrolled veterans. Coupling this with the push for VA to drive down the cost of care while increasing the number of veterans served puts long-term care at a disadvantage, and all the more for institutional extended care. The DAV believes that long-term care is a fundamental part of the continuum of VA medical care. We therefore urge Congress and VA to address this aspect of the current state of VA long-term care as you consider the future of this essential program.

Non-Institutional Long-Term Care

As referenced above, VA's enhanced authority to use and make available non-institutional services, including respite care, assisted living and residential care such as adult day healthcare, skilled home nursing, home-based care models, homemaker/home health aide services, was added to VA's medical benefits package by the Millennium Act. However, nearly four years post-enactment, the government Accountability Office (GAO) testified and reported these enhanced VA services remained highly variable from facility to facility, and from Veterans Integrated Services Network (VISN) to VISN. The information noted existing variations in availability of non-institutional services across VA due to, among other reasons, the lack of existence of particular programs at a given VA facility and whether the veteran resides within a facility's geographic service area.

More recently VA has reported large year-to-year increases in non-institutional long-term care activity, but VA's data conventions for reporting this workload, which assists VA's ability to manage this program's patient population, are problematic for the purposes of oversight and may misstate that activity.

While we applaud VA leadership in reinforcing the elimination of local restrictions limiting eligible veterans' access to non-institutional care, we continue to receive reports that service-connected disabled veterans are not receiving the care they need for their service-connected conditions because they do not reside in a VA facility's geographic service area. Moreover, we are concerned by the lack of systematic oversight to capitalize and advance the progress made in addressing this issue.

Hospice and Palliative Care

To address the number of veteran deaths that has been increasing by about 8 percent annually to a current average of 1,800 per day, VA has emphasized providing hospice and palliative care to honor personal preferences for care at the end of life. While hospice and palliative care are covered benefits available to all enrolled veterans in all settings, VA must offer to provide or purchase hospice and palliative care that VA determines an enrolled veteran needs.

Unfortunately, VA is the only public healthcare system that charges co-payments to hospice patients. Veterans who utilize this benefit may be subject to inpatient and outpatient co-payments if hospice is not provided in a VA nursing home bed.

The DAV recommends the fulfillment of Congress's original intent in Public Law 108–422 that VA provide equitable and compassionate end of life services to veterans by exempting them from the requirement to pay co-payments when they receive VA hospice care in any setting. We also urge greater Subcommittee oversight on VA's end of life programs as many VA facilities have been aggressive in establishing end of life programs while others have lagged behind.

Institutional Long-Term Care

VA Nursing Home Care Units

A common description of nursing home care is that it is the most restrictive and the least flexible mode of providing extended care services. Further, much like hospice care in its infancy, nursing home care is seen as an antithesis to medical care—a form of care in which patients will never recover or stabilize to the point where they can take care of themselves, or with a support system would be able go return home. While seemingly accurate, these observations do not fairly or entirely represent the value of institutional care, particularly for the veteran patient that suffers from serious chronic mental illness, spinal cord injury, behavioral problems, or is ventilator dependent and thus poses a significant problem for community placement.

On average, elderly enrolled veterans have a higher divorce rate, a higher rate of marital separation, lower incomes, savings and other personal assets than age-matched non-veteran populations. They are more likely to live alone, be estranged from families, less likely to engage in social and community activities, more likely to exhibit unhealthy lifestyles with respect to exercise, alcohol, tobacco, and nutrition, and exhibit more tendencies to chronic mental illnesses. Caring for an aging veteran population with some of these characteristics in the least restrictive setting may well be in VA nursing home care units, rather than in community settings.

Furthermore, the DAV believes that in addition to serving a specific patient population providing invaluable service such as indefinite self-care support, rehabilitative, and recuperative care, nursing home care is an integral component to VA's extended care benefits package as a part of that continuum. Moreover, VA's "Culture Transformation" initiative for nursing home care is centered on such core concepts as personal autonomy, privacy, dignity, flexibility, and individualized services. The culture change movement, which is well underway, is changing the old philosophy of patient centered care, which operates in a medical model of technical service delivery and intervention, and toward the new thinking of patient centered living in old age.

State Veterans Homes

The DAV is concerned about the obvious shift in VA's long-term care workload away from meeting its statutory mandate to maintain VA nursing home capacity. This policy is unconscionable considering VA's own projected demand that the anticipated capacity in all three institutional settings (VA nursing home care units, community nursing homes, and State Veterans Homes) will not be sufficient to meet the total demand of enrolled veterans for institutional nursing services.

While it is laudable that VA seeks to provide care to veterans who need VA the most by shifting more of its institutional care workload into State Veterans Homes, we applaud Congress for taking the first step to provide equitable relief for service-connected disabled veterans in State Veterans Homes through passage of section 211 of P.L. 109–461. This provision authorizes direct VA placement of service-connected veterans in State Veterans Homes, with VA reimbursement to the homes for the full cost of that care. We understand VA is moving forward rapidly to implement that provision with statutory regulations, and we commend VA for that action.

The *Crossroads* report included important recommendations dealing with State Veterans Homes, but one that VA has not implemented nor recommended that Congress authorize. The Crossroads report enthusiastically endorsed VA facilities' making significantly greater use of State veterans facilities to meet enrolled veterans' institutional care needs, rather than building additional VA in-house capacity for that purpose. Unfortunately, VA has done neither. It is true that State capacity has increased to about 21,000 average daily census (ADC) compared to the 1997 level of 14,039 ADC, but proportionately the workload remains at about 52 percent of VA's total nursing home capability. There are ample reasons for this stagnation, related to individual State financial conditions; lack of a formal relationship providing incentives for VA facilities to refer veterans directly to State care; lack of resources to address the growing State home construction backlog (now nearing $500 million); and, VA legal interpretations that block better relations between State and VA facilities. VA has long articulated a "partnership" with the States in long-term care, but DAV recommends some of these obstacles be surmounted or legislatively removed in order for a true long-term care partnership to be established between VA and the States.

Community Nursing Home Care

Mr. Chairman, in July 2001, GAO reported to Congress the results of its review of VA inspections of community nursing homes caring for VA-referred patients. As a general rule, VA requires its facilities to inspect State Veterans Homes and contract community nursing homes on an annual basis, and to make staff visits to community nursing homes on a monthly basis. While GAO was satisfied that State home oversight was sufficient at that time, GAO recommended additional oversight by VA Central Office over inspection activities of community nursing homes. DAV recommends the Committee ask GAO to repeat its review of the inspection and monitoring of State Veterans Homes and community nursing homes caring for veterans under VA auspices.

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans

Mr. Chairman, when we think of long-term care, we assume that these programs are reserved for the oldest veterans, near the end of life. Today, however, we confront a new population of veterans in need of specialized forms of long-term care—a population that will need comfort and care for decades. These are the veterans

suffering from polytraumatic injuries and traumatic brain injuries as a consequence of combat in Iraq and Afghanistan. In discussion with VA officials, including facility executives and clinicians now caring for some of these injured veterans, it has become apparent to DAV and others in our community that VA still needs to adapt its existing long-term care programs to better meet the individualized needs of a truly special and unique population, VA's existing programs will not be satisfactory or sufficient in the long run. In that regard, VA needs to plan to establish age-appropriate residential facilities, and additional programs to support these facilities, to meet the needs of this new population. While the numbers of veterans sustaining these catastrophic injuries are small, their needs are extraordinary. While today they are under the close supervision of the Department of Defense and its health agencies, their family members, and VA, as years go by, VA will become a more crucial part of their care and social support system, and in many cases may need to provide for their permanent living arrangements in an age-appropriate therapeutic environment.

Unresolved Policy Issues

Nearly a decade after issuance of the *Crossroads* report and enactment of the Millennium Act, and despite encouragement from this Subcommittee and others, VA remains without a clearly articulated policy on long-term care. We commend VA for adding new long-term care programs over those years, especially those dealing with home—and community-based approaches, but we were concerned in 2005 when the VA proposed that Congress further restrict long-term care eligibility and to probably deny access to VA long-term care to major segments of the veteran population, at a moment when the elderly veteran population was peaking. We thank this Subcommittee for its support of a continuation of current eligibility for these services.

As VA has ramped up community-based, non-bed programs such as home-based primary care, it has not changed its reporting conventions such that it still equates a day of care in a community-based or home-based program to that of a day of care in a nursing home or other institutional setting. This type of data collection and reporting may produce a distortion of activity or workload when in fact none may be present.

While VA has become highly efficient at converting its nonservice-connected community nursing home placements to Medicaid status, it has established no formal tie to the Centers for Medicare and Medicaid Services (CMS) or with the States to oversee that unwritten policy. Also with regard to institutional and home hospice, despite offering to purchase hospice VA refers thousands of veterans from its own program to those of Medicare without acknowledging it is doing so, while charging co-payments to dying veterans in its own hospice programs.

In the State Veterans Home program, VA claims to be participating in a "partnership" but only provides a per diem payment to the States as they deal with their veterans' long-term care burdens. Some VA facilities even deny access to enrollment and to specialized VA care for residents of State Veterans Homes on the basis that the homes are responsible for comprehensive care, not VA.

All these informal policies are working their will, but we question whether they are working to the betterment of the care of elderly veterans or simply are manifestations of ways to shift VA costs for long-term care to other willing payers. DAV does not expect VA to provide long-term care to every American veteran, but to the degree VA holds itself out as a provider of these services, DAV believes the policies under which it operates ought to be transparent and well understood. Neither case is true today.

Closing

Mr. Chairman, the future of VA long-term care planning remains uncertain. The lack of a strategic plan that involves stakeholder input is discouraging to DAV and others in this community. Also, as this Subcommittee conducts needed hearings on VA long-term care services, we urge the Subcommittee to provide stronger oversight of VA's unwritten long-term care policies to be sure they are equitable for veterans who need such care.

Although DAV advocates for a more comprehensive geriatric and extended care benefits package for service-connected disabled veterans regardless of their percentages of disability ratings, it is clear that VA's current policy reflects a struggle between what is expected and what it can deliver based on available resources. As the late Dr. Paul Haber said of VA in 1975 on the occasion of the establishment of the VA Office of Extended Care, *"As the number of aging veterans increases over the next decades, the Department will need to expend more resources for their care. Expanding services for old, chronically ill patients will cause disquietude among some in the*

Department." Although he was referring to the "Department of Medicine and Surgery," now known as the Veterans Health Administration (VHA), Dr. Haber's words still ring true today. The VHA is forced to choose between emphasizing institutional or non-institutional modes of long-term care, both of which are not available to the same population of enrolled veterans. These needs must compete internally with the funding of VA acute care and primary care services. Moreover, VA is operating with limited overall healthcare resources, making allocation decisions ever more difficult, and further hampered by the absence of clear direction due to inequities in existing authority in the eligibility criteria for institutional and non-institutional VA long-term care.

A continuum of care is essential to effectively meet the healthcare needs of our aging veteran population who live with complex medical, social, behavioral, and functional impairments, as well as to fully meet the needs of the newest generation of veterans injured by war. To ensure that veterans receive the benefits of these programs in a coordinated, integrated manner, a full array of non-institutional extended care services complemented with institutional geriatric care services must be available throughout each VISN, and accessible to all enrolled veterans.

Mr. Chairman, 25 years ago VA published a report entitled *Care for the Aging Veteran*. This was a landmark study and set the stage for many of the programs VA uses today to care for elderly veterans. One of the premises of that era was that VA would take the lead in the "graying of America," by establishing models of care in geriatrics and gerontology that would be emulated and replicated in other public and private systems of care. While we applaud the obvious progress VA has made, we observe most of the promise that was in the "Aging Report" has not materialized in long-term care policy in the United States. While we hope other Congressional Committees will eventually address the larger picture of an aging America and how to meet those needs, we urge this Subcommittee to establish clear guidelines for prioritizing among VA's existing and emerging programs and the eligibility of veterans to receive care in such programs. We hope the Subcommittee and your colleagues on the Appropriations Committees of both Chambers will ensure VA has the resources to meet the expectation to provide sick and disabled veterans the levels of care they need, including the needs of the programs we have addressed today in this testimony. Equally important, we urge Congress to continue to hold VA accountable in providing a full complement of high quality, cost effective geriatric and extended care services to aging veterans.

Mr. Chairman, we thank you for holding this important hearing to discuss the state of the VA's long-term care programs. While I have tried to bring forward relevant issues in long-term care that are important to DAV, the complexity, magnitude and impact of this program compel additional hearings. We urge the Subcommittee to consider holding those hearings in order for Congress to gain a fuller understanding on what needs to be done, for veterans and for all of our citizens as we age. As of today, much still remains despite the obvious progress we have observed.

This concludes my statement, and I will be happy to address any questions the Subcommittee may have.

Prepared Statement of Fred Cowell, Senior 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, quality long-term care services for our Nation's veterans. PVA's testimony is focused in three areas. First, we would like to draw your attention to the long-term care needs of America's returning heroes from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Thousands of these brave young men and women are facing lifelong challenges because of the severity of their wounds and will depend on VA non-institutional and VA institutional long-term care programs for much, if not all, of their lives. Second, our testimony will address the unique long-term care needs of veterans with spinal cord injury or disease (SCI/D) and the looming gap in providing specialized care for these men and women. Finally, we will address broad long-term care issues affecting all aging veterans and how a VA long-term care strategic plan can make a difference in their care.

Currently, VA provides an array of non-institutional (home and community-based) long-term care programs designed to support veterans in their own communities while living in their own homes. Additionally, VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA

provides nursing home care in VA operated nursing homes, under contract with private community providers, and in State Veterans Homes.

Mr. Chairman, PVA is a long time supporter of non-institutional long-term care programs because they have, in many cases, enabled aging veterans, our members, and other veterans with catastrophic disabilities to live independent and productive lives in the least restrictive setting. PVA has always believed that nursing home care must always be a choice of last resort and that no veteran should be forced into a nursing home just because of his/her spinal cord injury, spinal cord disease or other catastrophic disability.

However, many aging veterans and veterans with catastrophic disabilities live on a slippery slope even with the support of non-institutional long-term care. Slight changes in function associated with aging, a serious episode related to a secondary condition, or the loss of a care giver can plunge even a young veteran with a catastrophic disability down that slippery slope from independent living at home into institutional nursing home care. Therefore, it is imperative that VA continue to provide quality nursing home care not only for aging veterans but for those younger catastrophically injured veterans who cannot benefit from non-institutional long-term care services.

Young OIF/OEF Veterans

Mr. Chairman, PVA believes that age-appropriate VA non-institutional and institutional long-term care programming for young OIF/OEF veterans must be a priority for VA and your Subcommittee. New VA non-institutional and institutional long-term care programs must come online and existing programs must be re-engineered to meet the various needs of a younger veteran population.

VA's non-institutional long-term care programs will be required to assist younger injured veterans with catastrophic disabilities who need a wide range of support services such as: personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services. These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration (HISA) grant, and VA's adaptive housing and auto programs so they can leave institutional settings and go home as soon as possible. PVA also believes that VA's long-term care programs must be linked to VA's new polytrauma centers so that younger veterans can receive injury specific annual medical evaluations and continued access to specialized rehabilitation, if required, following initial discharge.

VA's institutional nursing home care programs must change direction as well. Nursing home services created to meet the needs of aging veterans will not serve young veterans well. As pointed out in The *Independent Budget,* VA's Geriatric and Extended Care staff must make every effort to create an environment for young veterans that recognizes they have different needs. Younger catastrophically injured veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire nursing home culture must be changed for these individuals, not just modified. For example, therapy programs, living units, meals, recreation programs, and policy must be changed to accommodate young veterans entering the VA long-term care system.

Veteran with Spinal Cord Injury or Disease (SCI/D)

PVA is concerned that many veterans with spinal cord injury and disease are not receiving the specialized long-term care they require. VA has reported that over 900 veterans with SCI/D are receiving long-term care outside of VA's four SCI/D designated long-term care facilities. However, VA cannot report where these veterans are located or if their need for specialized medical care is being coordinated with area VA SCI/D centers.

Today's VA SCI/D long-term care capacity cannot meet current or future demand for these specialized services. Waiting lists exist at the four designated SCI/D facilities. Currently, VA only operates 125 staffed long-term care (nursing home) beds for veterans with SCI/D. These facilities are located at: Brockton, Massachusetts (30 beds); Castle Point, New York (15 beds); Hampton, Virginia (50 beds); and 30 beds at the Hines Residential Care Facility in Chicago, Illinois. Geographic accessibility is a major problem because none of these facilities are located west of the Mississippi River. New designated VA SCI/D long-term care facilities must be strategically located to achieve a national geographic balance to long-term care to meet the needs of veterans with SCI/D that do not live on the East coast of the United States.

VA's own Capital Asset Realignment for Enhanced Services (CARES) data for SCI/D long-term care reveals a looming gap in long-term care beds to meet future demand. VA data projects an SCI/D long-term care bed gap of 705 beds in 2012 and

a larger bed gap of 1,358 for the year 2022. VA's proposed CARES SCI/D long-term care projects would add needed capacity (100 beds) but are very slow to come online. CARES proposes adding 30 SCI/D LTC beds at Tampa, Florida; 20 beds at Cleveland, Ohio; 20 beds at Memphis, Tennessee; and 30 beds at Long Beach, California. The CARES Tampa project is currently under construction but is not scheduled to open for another 2 years and the Cleveland project is currently in the design phase but remains years from completion. The Memphis and Long Beach projects have not even entered the planning stage at this time.

Methods for closing the VA SCI/D long-term care bed gap and resolving the geographic access service issue are part of the same problem for PVA. VA's Construction Budget for 2008 includes plans for new 120 bed VA nursing homes to be located in Las Vegas, Nevada and at the new medical center campus in Denver, Colorado. Also, VA has announced construction planning of a new 140 bed nursing home care unit in Des Moines, Iowa.

Mr. Chairman, PVA needs your support to ensure VA construction planning dedicates a percentage of beds at each new VA nursing home facility for veterans with SCI/D. PVA requests that Congress mandate that VA provide for a 15 percent bed set-aside in each new VA nursing home construction project to serve veterans with SCI/D and other catastrophic disabilities. These facilities will require some special architectural design improvements and trained staff to meet veteran need. However, much of the design work has already been accomplished by PVA and VA's Facility Management team. This Congressional action will help reduce the SCI/D bed-gap and help meet the current and future demand for long-term care. While a 15 percent bed allocation in new VA nursing home construction plus the proposed CARES LTC projects do not solve the looming bed gap problem in the short run it is a good first step and these additions will improve VA's SCI/D long-term care capacity in the western portion of the country.

Public Law 109–461 required VA to develop and publish a strategic plan for long-term care. PVA congratulates Congress on understanding the importance of this issue to ensure that America's catastrophically disabled and aging veteran population is well cared for. During the organization of VA's strategic long-term care plan PVA, calls on VA and Congress to pay careful attention to the institutional and non-institutional long-term care needs of veterans with SCI/D and other catastrophic disabilities. We request that PVA and other veteran service organizations have an opportunity to provide input and assist VA as it moves forward in the development of this important document.

Mr. Chairman, in the past and even today many veterans with spinal cord injury or disease and other catastrophic disabilities have been shunned from admittance to both VA and community nursing homes because of their high acuity needs. PVA believes that catastrophic disability must never be grounds to refuse admittance to VA or contract VA long-term care services. PL 109–461 requires VA to include data on, "the provision of care for catastrophically disabled veterans; and the geographic distribution of catastrophically disabled veterans." This information is critical if VA's strategic plan is to adequately address the needs of this population.

VA's Nursing Home Capacity Mandate

Congress has mandated that VA maintain its nursing home average daily census (ADC) at the 1998 level of 13,391 but VA has not done so (Chart 1.). Instead, VA has been steadily shifting its institutional long-term care workload to State Veterans Homes and to contract community (private sector) providers (Chart 2.). According to the government Accountability Office (GAO) (GAO Report # 06–333T), VA's overall nursing home workload for 2005 is split as follows: 52 percent State Veterans' Homes, 35 percent VA nursing homes, and 13 percent Contract Community nursing homes.

Chart 1. ADC for VA's Nursing Home Care Program

Year	Average Daily Census
1998	13,391
2004	12,354
2005	11,548
2006	11,434

Chart 1. ADC for VA's Nursing Home Care Program—Continued

Year	Average Daily Census
Decrease 1998–2006	1,957

Chart 2. ADC Increases in VA's Contract Community Nursing Home Program and in the State Veterans Homes Program

Contract Community Providers			
Year	**ADC**	**Year**	**ADC**
2004	4,302	2004	17,328
2005	4,254	2005	17,794
2006	4,395	2006	17,747
Increase 2004–2006	**93**	Increase 2004–2006	**419**

Despite clear VA data that highlights the aging of the veteran population and an associated increasing demand for services, the ADC for VA nursing home care continues to trend downward. This is especially concerning because of the nation's large elderly population. According to VA data, (VA Strategic Plan FY 2006–2011) veterans 85 and older represent 4.5 percent of the total veteran population and VA projects that by 2011, the number of veterans age 85 and older will grow to more than 1.3 million. Veterans 65 to 84 years old represent 33.9 of the total veteran population; and veterans 45 to 64 years old represent 41.4 percent of the total veteran population. VA goes on to say that the median age of all living veterans today is 60 years old.

Mr. Chairman, PVA calls upon Congress to enforce and maintain the nursing home capacity mandate as outlined in the Millennium Benefits and Healthcare Act. This capacity mandate sets a minimum floor of VA nursing home care at a critical time in our Nation's history. This is a critical point in time because members of America's "greatest generation" our World War II veterans, desperately require quality nursing home care and because of the demand being created today as America's newest and most severely wounded heroes are returning from Iraq and Afghanistan.

State Veterans Home's Life-Safety Issues

PVA's testimony has pointed out that State Veterans' Homes have been shouldering an increasing share of VA's nursing home care workload over the last few years. VA has found it cost-effective to utilize State Veterans' Homes because the expense of this care is shared by both VA and the States. However, as increased numbers of veterans utilize the State Veterans' Homes program VA must accept increased responsibility for the up-keep of these facilities. Congress and VA must move quickly to provide needed funding to address life-safety construction issues that exist in these State Veterans' Homes. The *Independent Budgetet* supports an appropriation that provides $150 million to correct these

facility deficiencies. While $150 million does not meet the $250 million overall cost needed to correct the entire priority-1 life-safety problem list, it is a good first step toward bringing these facilities into a safer condition.

Wiating Lists for VA Non-Institutional Long-Term Care

PVA is concerned about reports from our members and from VA officials that long waiting lists exist for aging veterans who need access to VA's non-institutional long-term care programs. Many of VA's Home-Based Primary Care programs have extended waiting lists for veterans who need the range of services associated with that program. Some waiting times are approaching almost a year before a veteran can enter the program and receive nursing visits at home. PVA also understands that VA's Adult Day Care Program, its Contract Adult Day Care Program, and it Homemaker/Home Health Aide Services programs also have extended waiting periods for admission.

These are the types of VA non-institutional long-term care programs that can prevent, in many cases, or delay more expensive and more restrictive nursing home care. Mr. Chairman, in plain economical terms the return on investment related to VA's non-institutional long-term care programs is overwhelmingly positive. Additionally, these programs are exactly what veterans want. America's aging veterans want to remain in their own homes and communities as long as possible. We call on your Subcommittee to review the demand, availability and associated waiting lists for VA non-institutional long-term care programs and to provide the resources necessary to enable VA to expand these valuable programs that are favored by veterans.

VA's Care Coordination Program

VA's Care Coordination/Home Telehealth (CCHT) Program provides a range of services designed to help older veterans with chronic conditions such as diabetes, heart failure, and Post Traumatic Stress Disorder to remain in their own homes and receive non-institutional VA care services.

CCHT is a relatively new VA program that resulted from a VA pilot program in VISN 8 between 2000 and 2003. VA implemented its national care coordination program in July of 2003. Each veteran patient being supported by CCHT has a care coordinator who is usually a nurse practitioner, a registered nurse or a social worker. In some complex cases physicians coordinate the patients care.

PVA believes that care coordination is an important element in VA's medical service toolkit that can help reduce expensive episodes of inpatient hospital care and enable aging veterans with chronic conditions to remain in their homes longer than ever before. This valuable VA program's reach should be extended and closely linked to VA's Geriatric and Extended Care Program to reach additional chronic care patients and bring the advantages of modern medical technology to their doorstep. VA's strategic plan for long-term care should find ways to integrate its CCHT program into a comprehensive mix of services for older veterans and veterans with catastrophic disabilities.

Assisted Living

Assisted Living has proven itself to be a desired alternative to nursing home care for many Americans. Consequently, Congress mandated that VA, via the Millennium Benefits and Healthcare Act, conduct a pilot project to provide assisted living services for veterans. VA did so between January of 2003 and June of 2004. The pilot project was conducted in VISN–20 and included seven medical centers in four states. VA's subsequent report on the project was forwarded to Congress by Secretary Principi in November of 2004. The report revealed a number of positive findings including information on cost, quality of care and veteran satisfaction.

The *Independent Budget* has called for the Assisted Living Pilot Project to be replicated in at least three VISN's with high concentrations of elderly veterans. VA's strategic long-term care plan must explore all available programs and services that provide quality community-based long-term care. An extension of VA's original assisted living project is one of those opportunities.

Conclusion

Mr. Chairman, PVA believes that one of the most positive moves by Congress in recent years has been to require VA to develop a strategic long-term care plan. However, for this new VA plan to be a success it must have positive and achievable recommendations and provisions for accountability. Performance measures, program evaluation, wait times, patient satisfaction surveys, and outcome measures are all elements that must be used in the development, monitoring and periodic revision of a strategic plan for long-term care. PVA believes that VA' strategic plan for long-term care must not just be a static, one time, report but one that is a living document that receives constant review and up/dates to be capable of responding to changing veteran needs and innovations in long-term care services.

PVA supports a VA strategic long-term care plan that monitors the appropriate balance between non-institutional and institutional long term care programs. When periods of projected peak program demand exist, VA and Congress must be flexible enough to concentrate resources to meet that demand. For example, the growing number of veterans 85 and older is well documented and their increased need for nursing home care must force VA to maintain adequate levels of nursing home bed space to accommodate that need. Correspondingly, when veteran demographics and demand shift, resources should follow demand and flow to alternative services.

PVA believes that VA's strategic plan will enable Congress to make better informed decisions regarding the provision of adequate financial resources to support VA care. Additionally, the strategic plan will assist VA's planning and monitoring efforts to ensure appropriate programming,

systemwide availability and quality of services. We hope that both your Subcommittee and VA utilize the knowledge and experience of America's Veterans Service Organizations in the development of a strategic plan for VA long-term care.

Prepared Statement of Patricia Vandenberg, MHA, BSN
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING
VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today, accompanied by James F. Burris, MD, Chief Consultant Geriatrics and Extended Care to discuss the strategic direction and plan for the future of long term care in the Department of Veterans Affairs (VA). I would like to take this opportunity to give an overview of VA's long-term care services and programs.

Growing Need For Long-Term Care

VA has testified previously that there is a great and growing need for long-term care services for elderly and disabled veterans. Between 2005 and 2012, the number of enrolled veterans aged 65 and older is projected to increase from 3.45 million to 3.92 million. The number of enrolled veterans aged 85 and older will increase from 337,000 to 741,000 during the same period. This latter group, those aged 85 and older, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care services, but also other healthcare services along the continuum of care such as acute care and preventive care.

VA is addressing the mandates for nursing home care for service-connected veterans with a disability rated at seventy percent or greater and veterans who need nursing home care for their service-connected disability and for selected home and community based care services for all enrolled veterans, as set by Congress in the Veterans Millennium Healthcare and Benefits Act, Public Law 106–117, and prioritizing care for those veterans most in need of our services including:

- veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) service,
- veterans with service-connected disabilities,
- veterans with lower incomes, and
- veterans with special healthcare needs such as serious chronic mental illness and spinal cord injury and disease

Since many enrolled veterans are also eligible for long-term care 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 the goal of providing compassionate, and high-quality care. VA staff have extensive experience in coordinating services among agencies for the benefit of veterans, within statutory limitations and in accordance with desires of patients and their families. 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 healthcare providers work closely with patients and family, on a case-by-case basis, to coordinate the veteran's various Federal and State benefits, and to maximize options for that veteran. Among those programs within VA that address coordinating veteran care needs are Social Work Service, Home Based Primary Care Program, community health nurse coordinators, and Care Coordination/Telehealth.

SPECTRUM OF VA LONG–TERM CARE SERVICES

VA's philosophy of care, in keeping with practice patterns throughout the public and private sectors, is to provide patient-centered long-term care services in the least restrictive setting that is suitable for a veteran's medical condition and personal circumstances, and whenever possible, in home and community-based settings. This approach honors veterans' preferences at the end of life and helps to maintain relationships with the veteran's spouse, family, friends, faith and community. Nursing home care should be reserved for situations in which the veteran can no longer be safely maintained in the home and community. VA long-term care is composed of a dynamic array of services provided in residential, outpatient, and inpatient settings that can be deployed as needed to meet a veteran's changing healthcare needs over time. In addition to direct patient care services, VA supports important research and education related to the healthcare needs of elderly and disabled vet-

erans through the work of its 21 Geriatric Research, Education, and Clinical Centers, or GRECCs.

Non-institutional Care Programs

VA's strategic goal is to make non-institutional long-term care services available to every enrolled veteran who needs them and seeks them from VA. The spectrum of non-institutional home and community-based long-term care services supported by VA includes:

- Home Based Primary Care,
- Contract Skilled Home Care,
- Homemaker/Home Health Aide,
- Adult Day Healthcare,
- Home Respite,
- Home Hospice, Spinal Cord Injury Home Care, and
- Care Coordination/Home Telehealth.

VA also provides quality oversight of care purchased by veterans in Community Residential Care and Medical Foster Home facilities through an annual review process and monthly or more frequent monitoring by VA staff.

The workload in the non-institutional care programs included in Long-Term Care has grown from an average daily census 19,810 in 1998 to 29,489 through the end of FY 2006. More than 9 out of 10 VA Medical Centers now offer some or all of these services, substantially enhancing veterans' access to non-institutional long-term care services. VA continues to have a VISN performance measure to increase the average daily census of veterans receiving home and community-based care. Each VISN has been assigned targets for increase in their non-institutional long-term care workload. VA is expanding both the services it provides directly and those it purchases from providers in the community.

Care Coordination Initiative/Home Telehealth

VA expects to meet a substantial part of the growing need for long-term care through such innovative services as Care Coordination/Home Telehealth. Care Coordination in VA involves the use of health informatics; telehealth and disease management technologies to enhance and extend existing care; and case management activities. VA's national Care Coordination initiative commenced in 2003 and is supported by a national program office. Care Coordination enables appropriately selected veteran patients with chronic conditions such as diabetes and congestive heart failure to remain in their own homes, and it defers or obviates the need for long-term institutional care. Care Coordination services are linked not only with services for the elderly such as Home Based Primary Care, but also with other services including Mental Health Intensive Case Management and General Primary and Ambulatory Care. Care Coordination/Home Telehealth enables delivery of VA healthcare to veterans living remotely from VA medical facilities, including those in rural areas.

Nursing Home Care

Inevitably, some veterans will be unable to continue to live safely in the community and will require nursing home care. VA will continue to provide nursing home care for all veterans for whom such care is mandated by statute, who need such care and seek it from VA. In addition, VA will continue to provide post-acute care for veterans who have suffered an accident or illness such as a broken hip or stroke, who require a period of recovery and rehabilitation before returning to the community. VA will also continue to provide nursing home care for veterans with special needs, including those with spinal cord injury or disease, ventilator dependence, and serious chronic mental illness. VA expects to sustain existing capacity in its own Nursing Home Care Units and in the Community Nursing Home Program and to support continued expansion of capacity in the State Veterans Home Program. Transforming the culture of care in nursing homes from the traditional medical model to a more home-like, patient-centered model is an important initiative in all of our nursing home programs.

State Veterans Homes

VA's State Veterans Home Program assists states in providing care to veterans in State Veterans Homes. Veterans' eligibility for each state's program is determined by the individual state using the state's own criteria. There are State Veterans Homes in operation or under construction in all 50 states and Puerto Rico. VA supports construction and renovation of State Veterans Homes through the State Home Construction Grant Program, which provides matching funds to assist states in purchasing, constructing, and renovating properties to serve as nursing

homes, domiciliaries, and adult day healthcare centers. Projects are funded in priority order until available funds for each fiscal year are exhausted, with highest priority given to renovation projects needed to correct life safety deficiencies and for construction of new capacity in geographic areas of need.

The second component of the State Veterans Home is the Per Diem Program. VA pays a per diem to assist the states in providing care for eligible veteran residents. Recently, Public Law 109–461, section 211 provided VA authority to pay State Veterans Homes the prevailing rate or the home's daily cost of care, whichever is less, for veterans in need of such care for a service-connected disability and for veterans who have a service-connected disability rated at 70 percent or more. VA is currently in the process of developing regulations to implement the provisions of this authority.

Thirdly, we provide medication at VA expense to eligible veterans residing in State Veterans Homes.

The fourth component of the State Veterans Home program is VA's oversight function. VA has developed a system of on-site inspections to assure quality of care in State Veterans Homes, including the identification of life safety issues.

The VA Deputy Secretary charged a VA Task Force earlier this year to explore opportunities for State Veterans Homes to provide non-institutional care for veterans. The Task Force solicited the views of representatives of the State Veterans Homes and State Departments of Veterans Affairs, who indicated that the most important need is to lower barriers to their participation in the Adult Day Healthcare program. VA will revise the regulations for the State Home Adult Day Healthcare program accordingly. Also, VA increases the per diem payment for this program annually, which should encourage greater participation by the states. VA staff responsible for the State Home Program communicate frequently with State Veterans Home and State Department of Veterans Affairs personnel to answer questions, share information, and solicit stakeholder input on VA policies and programs.

FUTURE NEEDS

The total FY 2008 budget request for long-term care is $4.6 billion, of which 90 percent will support institutional services and 10 percent non-institutional home and community-based care. This request will provide the resources necessary for VA to strengthen our position as a leader in providing high-quality services for a growing population of elderly and disabled veterans, as well as those veterans returning from service in OEF/OIF, veterans with service-connected disabilities, veterans with lower incomes, and veterans with special healthcare needs.

As you know, the population of veterans who are enrolled for healthcare in the VA are, on average, older, poorer, and sicker than the general population. VA is already seeing the kinds of demographic changes that are projected for the nation as a whole in coming decades. Recently, VA has also begun to care for younger veterans who have sustained polytraumatic injuries during their service in Operation Enduring Freedom and Operation Iraqi Freedom. While the number of seriously disabled OEF/OIF veterans is relatively small, compared to the total number of veterans requiring extended care services, the complexity of care they require is high and their personal and social needs differ from those of older veterans. VA is moving to adapt its long-term care services to meet the needs of all veterans.

Many returning veterans are presenting with multiple and severe disabilities including speech, hearing and visual impairment as well as loss of limbs and brain injuries, and behavioral issues due to the stress of combat. In addition, they have families, including children, who want to be actively involved in their care. Unlike other cohorts of veterans in long-term care, this cohort thrives on independence, is physically strong, and is part of a generation socialized differently than their older counterparts. These generational differences pose unique challenges in the institutional and long-term care environment.

VA is taking measures to first recognize the generational differences of this population and incorporate them into the care routines. For example, in VA nursing homes, transforming the culture of care to make the living space more home friendly is important, as is having an "Internet cafe", computer games, or age appropriate music and videos available for nursing home residents. Allowing for family, especially children, to visit and perhaps even stay over when needed is another example of accommodating generational differences. Personalizing care routines such as bathing and dining times and offering food items that are palatable to younger persons are examples of the changes that are occurring in long-term care.

Conclusion

VA takes great pride in our accomplishments, and looks forward to working with the members of this Subcommittee to continue the Department's tradition of pro-

viding timely, high-quality healthcare to those who have helped defend and preserve freedom around the world.

Mr. Chairman, this completes my statement. I will be happy to address any questions that you and other Members of the Subcommittee may have.

Statement of American Healthcare Association

On behalf of the nearly 11,000 long term care facilities represented by the American Healthcare Association (AHCA), we salute the Veterans' Affairs Committee for not only recognizing the needs of America's frail, elderly, and disabled veterans, but also for continually seeking to optimize the quality of their care in the face of substantial budgetary and demographic challenges.

In light of the increasing number of aging baby boomer veterans now seeking to access VA healthcare services, the increased care needs for older veterans already enrolled, and younger wounded veterans now in need of care, we recognize and are extremely sympathetic to the fact the VA's resource base and capacity are stretched to the maximum limit, and then some.

Consequently, it may not have the resources to address the existing and projected needs for skilled nursing and rehabilitative care—especially in light of the type and nature of injuries being sustained in Iraq and Afghanistan. From this important standpoint, Mr. Chairman, we want to support the VA's essential mission one hundred percent—not somehow impede or supplant it in a manner that prevents our returning heroes from receiving the best care our grateful nation has to offer. Our nation's community nursing homes (CNHs) stand ready to help veterans and the VA through this crisis.

CNHs are a vital component of the VA long term care system. Whereas VA medical facilities tend to provide care to residents with high acuity levels, CNHs are an excellent choice for veterans who either have acuity levels that do not warrant placement in a VA facility, but are too high for home healthcare—or for veterans who would be too far from their families if placed in one of their state's VA Medical Facilities or State Veterans Nursing Homes. In 2006, over 13 percent of all veterans receiving nursing home care were in CNHs. That percentage should increase, given the VA's stated plan in the FY 2008 Budget Submission to focus its long term care efforts on the "best setting for the [veteran] . . . and providing that care closer to where the veteran lives." Given that there is a skilled nursing facility in almost every county in the nation, AHCA remains ready to help the VA continue providing high quality, clinically appropriate long term care to our Nation's veterans through CNH placements.

By 2012, there are expected to be approximately 1.3 million veterans over 85 years of age, and it is imperative that we work together to insure that both the veteran and civilian populations receive the best possible care, and that one population should not receive care at the expense of another.

One key issue negatively impacting our ability to serve veterans and others in need of long term care is the ongoing staffing crisis, and we need to ensure that we do not compete against one another for the shrinking pool of qualified workers who serve as the backbone of our Nation's long term care system. In that context, we should fundamentally reevaluate elements of the Veteran's Millennium Healthcare and Benefits Act 1999—which established new standards for evaluating a state's need for constructing new facilities for veterans.

Specifically, the methodology for establishing the need for new veterans' beds does not take into account the number of available community nursing home (CNH) beds in each state—beds immediately available, and which may be far closer to home. CNHs provide the option of living closer to one's family while receiving health benefits from the VA. As we all know, proximity to loved ones is critical in maintaining quality of life for any nursing home resident.

For the record, Mr. Chairman, AHCA does not discourage in any way funding necessary improvements to veteran's homes. But we ask that prior to appropriating millions in construction costs for additional facilities, the VA should work to determine whether there are existing quality facilities in proximity to the proposed new homes that could otherwise provide high quality care.

In an era of limited resources, especially at the VA, we should as a matter of intelligent public policy work to provide care in homes that currently exist, rather than constructing new facilities that, again, compete for staff and weaken our Nation's entire long term care infrastructure.

AHCA looks forward to working with you, Mr. Chairman, and the rest of the Committee, in examining this issue in greater detail going forward. Our members

are proud to serve America's veterans in their time of need and we look forward to working with the Committee and the Department to continue doing so in the future.

Thank you again Mr. Chairman, and Members of this Committee, for holding this important hearing. With our Nation's soldiers and veterans in both the national and international spotlight, our concern for their care and safety today as well as tomorrow has never been more important to the soul and conscience of the American people. They deserve the best we have to offer.

Statement of American Occupational Therapy Association

The American Occupational Therapy Association (AOTA) submits this statement for the record of the May 9, 2007 hearing. We appreciate the opportunity to provide this information regarding the use of occupational therapy in long-term care in the Department of Veteran Affair's long-term care programs. With the aging of our Nation's veterans, quality long-term care programs to assist those who are in need should be a priority for our country. Occupational therapists and occupational therapy assistants work in long-term care settings, including home and community based settings, to increase the independence and quality of life of their patients.

AOTA is the nationally recognized professional association of 35,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is a health, wellness, and rehabilitation profession working with people experiencing stroke, spinal cord injuries, cancer, congenital conditions, developmental delay, mental illness, and other conditions. It helps people regain, develop, and build skills that are essential for independent functioning, health, and well-being. Occupational therapy is provided in a wide range of settings including daycare, schools, hospitals, skilled nursing facilities, home health, outpatient rehabilitation clinics, psychiatric facilities, and community programs.

Occupational therapy professionals assist those with traumatic injuries—young and old alike—to return to active, satisfying lives by showing survivors new ways to perform activities of daily living, including how to dress, eat, bathe, cook, do laundry, drive, and work. It helps older people with common problems like stroke, arthritis, hip fractures and replacements, and cognitive problems like dementia. In addition, occupational therapists work with individuals with chronic disabilities including mental retardation, cerebral palsy, and mental illness to assist them to live productive lives. Occupational therapy practitioners also provide care to veterans who suffer from traumatic brain injuries, post-traumatic stress disorder, spinal cord injuries, and other conditions. By providing strategies for doing work and home tasks, maintaining mobility, and continuing self-care, occupational therapy professionals can improve quality of life, speed healing, reduce the chance of further injury, and promote productivity and community participation for veterans.

The Department of Veterans Affairs (VA) offers a spectrum of geriatric and extended care services to veterans enrolled in its healthcare system. More than 90 percent of VA's medical centers provide home- and community-based outpatient long-term care programs. This patient-focused approach supports the wishes of most patients to live at home in their own communities for as long as possible. In addition, nearly 65,000 veterans will receive inpatient long-term care this year through programs of VA or state veteran's homes.

Occupational Therapy's Role for veterans in Long-term Care Programs

Occupational therapy practitioners provide care in a number of settings and programs, including both institutional and non-institutional programs. Veterans long-term care programs include options to receive care in the home and community as well as in nursing homes. Regardless of setting or program, it is proven that elderly individuals benefit from occupational therapy services *[Journal of the American Medical Association (JAMA) "Occupational therapy for independent-living older adults: A randomized controlled trail." JAMA, Vol. 278, No. 16, p. 1321–1326. 1997].* Occupational therapy practitioners can provide a unique and valuable service in supporting veterans in long-term care programs, in their occupations and activities of daily living, and in their efforts to remain independent and to successfully age in place.

Activities of Daily Living (ADLs) are basic self-care activities that need to be completed on a daily basis (for example self-feeding, grooming, bathing, dressing, and toileting). Instrumental activities of daily living (IADLs) such as reading and managing money are also critical. Occupational therapy practitioners work with veterans to gain the skills that are needed to accomplish their ADLs and pursue IADLs

as appropriate. Occupational therapists and occupational therapy assistants are experts at identifying the causes of difficulties limiting participation. Their expertise enables them to consider client needs and environmental factors to develop effective strategies that will maximize quality of life as well as independence in those daily activities that are important to each Veteran.

Veterans who wish to age in place in their home or community look toward occupational therapy as a means to achieve their goals. Occupational therapy plays a key role in identifying strategies that enable individuals to modify their homes and environment to meet their goal of aging in place at home and in the community. Aging in place refers to the ability to remain in the home even if the client's abilities have declined.

Home modifications are adaptations to living environments intended to increase usage, safety, security, and independence for the user. As part of the home modification process, occupational therapy services include assessing needs, identifying solutions, implanting solutions, training in the use of solutions, and evaluating outcomes that contribute to the home modification product. Occupational therapy practitioners may recommend the installation of chair lifts for stairs or adding railings or grab bars to bathrooms or other walls to provide support. Occupational therapy practitioners can enhance Veteran's well-being and participation by serving as a resource in home modification.

Occupational therapy is also recommended to help keep individuals mobile and independent, helping to ensure meaningful participation in the community. For some people, some forms of transportation, such as driving, become less safe, and many veterans will need to address alternatives to driving at some point in their lives. Occupational therapy can optimize and prolong an older driver's ability to drive safely, and ease the transition to other forms of transportation if driving cessation becomes necessary. By identifying strengths as well as physical and cognitive challenges, occupational therapists can evaluate an individual's overall ability to operate a vehicle safely and recommend assistive devices or behavioral changes to limit risks. The goal of assessing individuals for driving is to enable them to stay in the community and reduce the need for nursing home care.

Veterans who receive care in nursing homes also benefit from occupational therapy services. Occupational therapy starts where the person is, looks at their desires and potential, and facilitates diminishment of frailties and support of abilities. As veterans are treated in nursing homes, their needs range widely. Occupational therapy is there to assist and enable them to overcome or heal from disability and illness. It is a critical component to achieving quality of life which is the goal of the Veteran Affair's long-term care programs. The veteran population will continue to grow and nursing homes will remain an important site of care for veteran's who require constant nursing care and have significant deficiencies with activities of daily living.

People in the United States are living longer, and that includes our Nation's veterans. For some, a consequence of increased longevity is increased frailty and dependency. Many veterans live alone, have limited resources, and require special services for meeting everyday needs. Helping elderly persons to maximize their independence and enabling them to continue to perform activities of daily living is crucial. The Department of Veterans Affairs long-term care programs are structured to provide care to our country's veterans as they age and need help with various areas of their lives. Occupational therapy is a unique and valuable service that can help veterans achieve their goals of living a healthy and independent life.

AOTA hopes that Congress will continue to look at occupational therapy as a service that benefits all Americans. We look forward to discussing how we can better serve our Nation's veterans and all aging Americans.

Contact: Daniel R. Jones

Statement of Kimo S. Hollingsworth, National Legislative Director
American Veterans (AMVETS)

Mr. Chairman and Members of the Subcommittee:

I am pleased to offer testimony on behalf of American veterans (AMVETS) regarding the Department of Veterans Affairs long-term care program.

The Department of Veterans Affairs (VA) offers a fairly robust variety of inpatient long-term care services for veterans enrolled in the VA healthcare system. VA services are generally divided into non-institutional care and institutional care. More than 90 percent of VA medical centers provide home and community-based outpatient long-term care programs. Overall, eligible veterans can receive home-based

primary care, contract home healthcare, adult day healthcare, homemaker and home health aide services, home respite care, home hospice care and community residential care. In addition, VA nursing home programs include VA-operated nursing home care units, contract community nursing homes and state homes.

As this Committee is aware, AMVETS hosted the "National Symposium for the Needs of Young Veterans" in Chicago, Illinois last year. More than 500 veterans, active duty and National Guard and reserve personnel, family members, and others who care for veterans examined the growing needs of our returning veterans. One of they Symposium findings revealed a general lack of knowledge about VA long-term care programs among veterans and their family members.

Mr. Chairman, the changing dynamics within the enrollee population, such as aging, changes in morbidity, and VA enrollees shifting to a higher cost priority level will continue to impact medical care expenditures. In testimony before the House Committee on Appropriations, VA recently reported, "that there is a great and growing need for long-term care services for elderly and disabled veterans." VA projects that between 2005 and 2012, the number of enrolled veterans aged 65 and will increase from 3.45 million to 3.92 million, and the number of enrolled veterans aged 85 and older will increase from 337,000 to 741,000 during the same period. The latter group will most likely require long-term care services and other healthcare services along the continuum of care such as acute care and preventive care.

Public Law 106–117 mandated that VA prioritize care for those veterans most in need of VA services, to include veterans returning from OEF/OIF service, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs such as serious chronic mental illness and spinal cord injury and disease. It is within the guidelines of this mandate that VA is currently focused. AMVETS reaffirms its commitment that service-disabled veterans should have the highest priority access to VA healthcare services and these services should be of the highest quality. AMVETS believes that service-connected veterans currently have that level of access and quality in VA today.

In 2004, VA commissioned a study on VA Long-Term Care Patients' Medicare and Medicaid Expenditures. The study concluded that three quarters of VA long-term care patients rely to some extent on the national Medicare and Medicaid programs. The study also found that VA funds approximately 90 percent of the care provided for these veterans. Given these dynamics of cross enrollment, AMVETS believes that it is in the interest of both the government and veterans to coordinate the benefits of their various programs and work together toward the goal of providing compassionate, and high-quality care.

Overall, the Veterans Health Administration's 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. As part of this process, VA healthcare providers work closely with patients and family to ensure veterans receive appropriate care. Despite VA's best efforts to coordinate care through its many programs and with other federal, state and private organizations, the cost of long-term care is expensive and continues to rapidly increase.

To VA's credit, the department has effectively managed its healthcare expenditures and it provides a significant dollar cost value compared to other Federal and private programs. From 1996 through 2004, the Medical Consumer price index increased by approximately 40 percent. During this same period, the average Medicare cost per payment per enrollee increased by almost 45 percent. The VA cost per patient during this same time period increased less than 1 percent, yet VA customer service and satisfaction ratings have increased. Ultimately, good business practices make sense, but VA is in the people business and taking care of veterans remains paramount. VA has done both!

AMVETS will continue to support VA long-term care programs and believes that the department continues to set the standard for excellence in care and dollar cost value per patient. AMVETS would continue to urge Congress to support VA long-term care programs and seriously consider allowing VA to recoup Medicare and Medicaid reimbursements as a way to save money for the Federal Government.

Mr. Chairman, this concludes my testimony.

Statement of Hon. Jeff Miller
Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman. I appreciate having this important hearing to look at the performance of the Department of Veterans Affairs (VA) in meeting the existing

long-term care needs of our disabled and aging veterans and assess the Department's strategy for addressing long-term care challenges in the future.

The number of enrolled veterans most in need of long-term care services, those 85 years and older, will dramatically increase by the year 2012, growing from 337,000 to 741,000 veterans, a 120 percent increase. In addition to a large elderly veteran population, VA is facing a new demographic of veterans who are limited in their capacity to care for themselves due to multi-trauma injuries incurred during the Global War on Terror. It is vital that the generational differences of these young veterans be taken into consideration and that VA provides age-appropriate services in the right setting.

In 2003, 2004, 2005 and 2006 the government Accountability Office analyzed various aspects of VA's long-term care programs at both the House and Senate Committees' direction. It is of great concern that in these GAO reviews, we continue to find that access to a complete continuum of VA long-term care services remains markedly variable from network to network.

VA's lack of a reliable long-term care planning model not only led to a glaring gap in the Capital Asset Realignment for Enhanced Services (CARES) plan, but was also a major factor in the budget formulation problems this Committee uncovered in 2005. For more than five years, VA has been promising to adopt a strategic plan for long-term care, but has failed to establish one. Last year, in Public Law 109–461, Congress showed its resolve by requiring VA to publish a strategic plan for the provision of long-term care not later than 180 days after enactment of the law. Let me put VA on notice that the date is near and we expect VA to submit that plan in mid-June, on time, with no excuses.

I want to also remind all of us that the way VA delivers long-term care very deeply affects each individual veteran patient and their families. Important to enhancing a veteran patient's quality of life is ensuring that care is provided in the least restrictive setting and that the personal dignity and emotional well-being of the patient is the top priority. In this regard, I am a strong advocate for supporting new and innovative programs to meet these needs.

I look forward to the testimony our witnesses will provide today to assist us in confronting the unresolved issues related to meeting the long-term care needs of all our veterans and improving the management and direction of VA's long-term care mission.

Thank you Mr. Chairman, I yield back.

Priority List of Pending State Home Construction Grant Applications for FY 2007

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Application Subject to 38 CFR 59.50(b) Priority Group 1		
1	06-044	CA (Greater LA Complex) ** P	520-Bed NHC/DOM (New)	1, 3	163,421
			Applications Subject to 38 CFR 59 Priority Group 1		
2	32-002	NV (Boulder City)	L/S Dietary Facility Corrections	1, 1, 2	1,429
3	13-008	GA (Milledgeville) **	L/S NFPA Code Correction (Sprinkler Russell Building)	1, 1, 2	991
4	20-004	KS (Ft. Dodge)	L/S Back-Up Generators	1, 1, 2	401
5	13-012	GA (Milledgeville)	L/S NFPA Code Correction (Sprinkler Russell Bldg), Phase 2	1, 1, 2	939
6	13-013	GA (Milledgeville)	L/S NFPA Code Correction (Sprinkler Vinson Bldg., Phase 2	1, 1, 2	536
7	27-037	MN (MInneapolis)	L/S Campus Emergency Electrical Egress & Back-Up Generator Upgrade	1, 1, 2	1,597
8	06-059	CA (Yountville)	L/S Member Services Building Fire Safety Improvements & Renovation	1, 1, 2	13,831
9	20-006	KS (Ft. Dodge)	L/S Fire Safety Facility Renovations, Install Overhead Sprinkler System 3 Buildings, Tornado Shelter, etc.	1, 1, 3	810
10	50-008	VT (Bennington) **	L/S Code Improvements, Mold & Asbestos Removal, Phase 1	1, 1, 4	1,394
11	13-010	GA (Milledgeville) **	L/S NFPA Code Correction (Sprinkler Vinson Bldg.	1, 1, 4	955
12	44-010	RI (Bristol) **	L/S Fire Safety Improvements	1, 1, 4	732
13	20-005	KS (Winfield)	L/S Back-Up Generator, Install Sprikiers in DOM, etc.	1, 1, 4	940
14	34-028	NJ (Paramus)	L/S Replace Fire Alarm System	1, 1, 5	307
15	17-037	IL (Quincy)	L/S Replace Fire Alarm System	1, 1, 5	260
16	18-002	IN (Lafayette)	L/S Replace Fire Alarm System, Install Sprinkler Sys. etc.	1, 1, 5	1,066
17	40-024	OK (Sulphur)	L/S General Renovations - Hazardous Materials	1, 1, 6	12,675
18	01-006	AL (Alexander City)	L/S Moisture Remediation, Phase 2	1, 1, 6	1,363
19	17-036	IL (Quincy)	L/S Mold Remediation	1, 1, 6	1,336
20	47-008	TN (Murfreesboro) **	L/S Moisture Remediation - 36 Bathrooms	1, 1, 7	748
21	33-006	NH (Tilton) **	L/S Facility Upgrades-Backup Generator, Fire Alarm, A/C etc.	1, 1, 7	1,914
22	37-008	NC (Salisbury)	L/S Potable Water, Steam/Chilled Water and Camera Sys.	1, 1, 7	1,006
23	17-041	IL (Manteno)	L/S Emergency Generator Replacement	1, 1, 7	455
24	06-044	CA (Greater LA Complex) ** P	520-Bed NHC/DOM (New)	1, 3	163,421
25	12-007	FL (St. Augustine)	120-Bed NHC (New)	1, 3	11,637
26	06-052	CA (Redding)	150-Bed NHC/DOM (New)	1, 3	17,572
27	06-053	CA (Fresno)	300-Bed NHC/DOM (New)	1, 3	25,864
28	55-025	WI (Union Grove)	Adult Day Health Care Renovation	1, 4, 1	586
29	27-018	MN (Minneapolis)	Adult Day Health Care Renovation	1, 4, 1	1,914
30	27-019	MN (Luverne)	Dementia Unit Renovation	1, 4, 2	568
31	27-021	MN (Silver Bay)	Nursing Care Space Renovation	1, 4, 2	499
32	08-014	CO (Homelake)	Upgrade Resident Support and Activity Areas	1, 4, 2	3,394
33	12-014	FL (Lake City)	Facility Renovation, Phase 2	1, 4, 2	2,043
34	13-009	GA (Milledgeville)	Renovation and Upgrade Wheeler Building	1, 4, 2	269
35	04-004	AZ (Phoenix)	Renovation, Phase 2	1, 4, 2	1,040

Priority List of Pending State Home Construction Grant Applications for FY 2007

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Applications Subject to 38 CFR 59 Priority Group 1 (continued)		
36	21-008	KY (Wilmore)	Renovate 3 Nursing Units	1, 4, 2	975
37	23-011	ME (Scarborough)	Renovate Alzheimer's Unit	1, 4, 2	404
38	17-035	IL (Manteno)	Replace Nurse Call System	1, 4, 2	295
39	19-032	IA (Marshalltown)	Sheeler and Loftus Buildings Replacement	1, 4, 2	15,600
40	55-044	WI (Union Grove)	ADA Renovation - Fairchild and Shemanske Halls	1, 4, 3	710
41	06-051	CA (Yountville)	Steam Distribution System Renovation	1, 4, 4	1,729
42	34-026	NJ (Paramus)	HVAC Replacement	1, 4, 4	356
43	06-054	CA (Yountville)	Telecommunications and Network Upgrade	1, 4, 4	1,950
44	17-032	IL (LaSalle)	Replace Roof and Water System	1, 4, 4	306
45	26-060	MA (Holyoke)	Masonry Restoration	1, 4, 4	478
46	39-020	OH (Sandusky)	Roof Replacement - Secrest Hall	1, 4, 4	552
47	39-022	OH (Sandusky)	Mechanical System Upgrade	1, 4, 4	1,560
48	55-039	WI (King)	Replace Windows - Olson Hall	1, 4, 4	267
49	55-041	WI (King)	2nd Water Supply Well	1, 4, 4	860
50	04-005	AZ (Phoenix)	Facility Renovation, Phase 3	1, 4, 4	780
51	29-016	MO (Cape Girardeau)	Replace Roof	1, 4, 4	639
52	36-012	NY (Stony Brook)	Renovate Building Systems and Utilities	1, 4, 4	725
53	45-004	SC (Anderson)	Roof Replacement	1, 4, 4	748
54	17-042	IL (Manteno)	Air Conditioning Chiller and Tower Replacement	1, 4, 4	761
55	55-045	WI (King)	Replace Domestic Water Pipes - Olson Hall	1, 4, 4	975
56	09-013	CT (Rocky Hill)	Domiciliary Renovations - Buildings 2, 3 and 4	1, 4, 4	5,397
57	13-005	GA (Milledgeville)	Dietary Facility	1, 4, 5	715
58	39-023	OH (Sandusky)	Kitchen Upgrade - Secrest Hall	1, 4, 5	260
59	29-015	MO (St. Louis)	Sprinkler Pipe Replacement	1, 4, 5	775
60	23-013	ME (Caribou)	Multipurpose Room Addition	1, 4, 5	354
61	19-031	IA (Marshalltown)	Dining & Activity Room Expansion	1, 4, 5	2,470
62	17-027	IL (LaSalle)	Bus & Ambulance Garage	1, 4, 6	566
63	34-025	NJ (Paramus)	Multipurpose Room Addition	1, 4, 6	1,415
64	27-030	MN (Hastings)	Water Supply Replacement	1, 4, 6	325
65	55-035	WI (Union Grove)	Aboveground Building Connectors	1, 4, 6	2,217
66	17-030	IL (Manteno)	Construct Storage Building	1, 4, 6	1,610
67	17-033	IL (Manteno)	Convert and Upgrade Courtyards	1, 4, 6	2,320
68	04-003	AZ (Phoenix)	Facility Renovation, Phase 1	1, 4, 6	364
69	39-021	OH (Sandusky)	Corridor Renovation	1, 4, 6	325
70	19-030	IA (Marshalltown)	Renovate Medical Clinic Space	1, 4, 6	520
71	08-015	CO (Walsenburg)	General Renovations	1, 4, 6	2,045
72	23-012	ME (South Paris)	Replace Flooring	1, 4, 6	353
73	55-043	WI (King)	Ceiling Resident Lift System	1, 4, 6	1,892
74	49-003	UT (Salt Lake City)	General Renovations	1, 4, 6	454
75	36-013	NY (Stony Brook)	Kitchen, Laundry, Elevator Upgrades	1, 4, 6	1,575
76	44-011	RI (Bristol)	General Renovations	1, 4, 6	1,204
77	51-007	VA (Roanoke)	General Renovations	1, 4, 6	341
78	48-008	TX (Pending)	160-Bed NHC (New)	1, 5	11,144
79	48-009	TX (Pending)	160-Bed NHC (New)	1, 5	11,144

Priority List of Pending State Home Construction Grant Applications for FY 2007

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Applications Subject to 38 CFR 59 Priority Group 1 (continued)		
80	37-004	NC (Pending - Eastern)	100-Bed NHC (New)	1, 5	8,147
81	37-005	NC (Pending - Western)	100-Bed NHC (New)	1, 5	8,147
82	55-032	WI (Union Grove)	24-Bed DOM Addition (New)	1, 6	1,625
83	49-002	UT (Ogden)	120-Bed NHC (New)	1, 6	10,994
84	04-002	AZ (Tucson)	180-Bed NHC (New) & 35 Participant ADHC	1, 6	18,671
85	17-031	IL (LaSalle)	80-Bed NHC Addition (New)	1, 6	4,881
86	55-036	WI (Chippewa Falls)	120-Bed NHC, Plus 40-Bed DOM (New)	1, 6	15,925
87	47-009	TN (Montgomery County)	120-Bed NHC, Plus 20-Bed Alzheimer's Unit (New)	1, 6	11,105
88	51-005	VA (Richmond)	80-Bed DOM (New)	1, 6	5,200
89	51-006	VA (Hampton)	240-Bed NHC/DOM (New)	1, 6	23,400
90	21-009	KY (Hanson)	40-Bed NHC (Addition)	1, 6	6,000
91	48-010	TX (Pending) ** 1	160-Bed NHC (New)	1, 5	11,144
92	48-011	TX (Pending) ** 1	160-Bed NHC (New)	1, 5	11,144
			Subtotal All Priority Group 1 Applications (Has State Matching Funds):		491,330

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Applications Subject to 38 CFR 59 Priority Groups 2-7		
93	50-009	VT (Bennington)	L/S Code Improvements, Mold & Asbestos Removal, Phase 2	2, 2	2,306
94	50-010	VT (Bennington)	L/S Code Improvements, Mold & Asbestos Removal, Phase 3	2, 2	2,200
95	40-026	OK (Claremore)	L/S HVAC Renovation	2, 2	16,250
96	42-020	PA (Holidaysburg)	L/S Electrical & Pumbing Renovation	2, 2	3,970
97	22-010	LA (Monroe)	L/S Shelter-In Place Generator Upgrade	2, 2	610
98	22-011	LA (Bossier City)	L/S Shelter-In Place Generator Upgrade	2, 2	610
99	25-063	MA (Chelsea)	L/S New Sprinkler System - 6 Buildings	2, 5	510
100	46-013	SD (Hot Springs)	L/S Facility Renovations	2, 5	2,295
101	34-027	NJ (Vineland)	L/S Install Emergency Generator	2, 7	341
102	39-024	OH (Georgetown)	L/S Security Upgrades, Phase 1	2, 7	330
103	39-025	OH (Georgetown)	L/S Security Upgrades, Phase 2	2, 7	331
104	22-009	LA (Jennings)	L/S Emergency Generator, Laundry and Alz. Wandering System	2, 7	863
105	12-008	FL (Pending)	120-Bed NHC (New)	4	9,418
106	12-009	FL (Pending)	240-Bed NHC (New)	4	16,980
107	12-010	FL (Pending)	120-Bed NHC (New)	4	9,857
108	12-011	FL (Pending)	240-Bed NHC (New)	4	17,760
109	26-015	MI (Marquette)	Renovate Nursing Unit and Roof Replacement	5, 2	557

Priority List of Pending State Home
Construction Grant Applications for FY 2007

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Applications Subject to 38 CFR 59 Priority Groups 2-7 (continued)		
110	39-027	OH (Sandusky)	Renovate Griffin Hall - First Floor	5, 2	418
111	27-032	MN (Minneapolis)	Building 17 Resident Room Upgrade	5, 2	1,196
112	39-030	OH (Sandusky)	Tub Room/Nurse Call System - Secrest & Griffin Bldgs.	5, 2	936
113	39-031	OH (Sandusky)	Domestic Water Lines Upgrade	5, 2	417
114	39-032	OH (Sandusky)	Floor Replacement - Secrest & Griffin Buildings	5, 2	579
115	17-040	IL (Quincy)	Renovations, Phase 3	5, 2	3,250
116	72-004	PR (Juana Diaz)	Facility Renovations - Patient Areas	5, 2	488
117	40-027	OK (Talihina)	Special Care Unit Renovations	5, 2	517
118	25-062	MA (Holyoke)	Renov. Resident Toilet/Baths	5, 3	439
119	25-061	MA (Holyoke)	Window Replacement, Phase 1	5, 4	325
120	06-056	CA (Yountville)	Central Power Plant Renovation	5, 4	740
121	55-040	WI (King)	Replace Lock and Key System	5, 4	2,098
122	55-042	WI (King)	Renovate Burns Clemons Hall	5, 4	5,574
123	39-026	OH (Sandusky)	HVAC Upgrade - Veterans Hall	5, 4	997
124	39-028	OH (Sandusky)	Mechanical System Upgrades, Phase 2	5, 4	275
125	39-029	OH (Sandusky)	Replace Exterior Lighting, Phase 2	5, 4	368
126	17-038	IL (Quincy)	Power Plant Renovation	5, 4	1,496
127	17-039	IL (Quincy)	Replace HVAC System	5, 4	975
128	21-010	KY (Wilmore)	Facility Renovations	5, 4	1,203
129	25-064	MA (Chelsea)	Water Tower Project	5, 4	650
130	22-007	LA (Jackson)	Generator, Mechanical & Sewer Treatment Renov.	5, 4	3,543
131	08-016	CO (Florence)	Roof and Exterior Finish Replacement	5, 4	523
132	06-047	CA (Yountville)	Chapel Renovation	5, 5	1,013
133	27-020	MN (Minneapolis)	Kitchen/Dining Room Renovation.	5, 5	2,844
134	06-058	CA (Chula Vista)	Expand Dining Room	5, 5	585
135	27-033	MN (Minneapolis)	New Chapel	5, 5	335
136	46-011	SD (Hot Springs)	General Renovations	5, 6	802
137	36-010	NY (St. Albans)	General Renovations	5, 6	4,470
138	27-029	MN (Minneapolis)	Renovation, Phase 2	5, 6	8,366
139	46-012	SD (Hot Springs)	Construct Chapel	5, 6	520
140	72-003	PR (Juana Diaz)	General Renovations	5, 6	650
141	06-057	CA (Yountville)	Administration Building Renovation	5, 6	2,946
142	27-034	MN (Minneapolis)	Renovate Building 13	5, 6	646
143	27-036	MN (Minneapolis)	Renovate Building 16, Phase 2	5, 6	13,068
144	22-008	LA (Jackson)	General Renovations	5, 6	2,893
145	13-011	GA (Milledgeville)	Alzheimer's Unit Addition	6	1,962
146	42-021	PA (Spring City)	112-Bed DOM Replacement + 8 Additional Beds	6	14,102
147	55-021	WI (King)	45-Bed Dom (New)	7	2,294
148	24-005	MD (Pending - Western)	120-Bed NHC (New)	7	7,684
149	39-017	OH (Pending)	168-Bed NHC (New)	7	7,800
150	39-018	OH (Pending)	168-Bed NHC (New)	7	7,800
151	53-030	WA (Orting)	120-Bed NHC (97 Replacement and 23 New)	7	8,316
152	27-022	MN (Fergus Falls)	Dementia - Special Care Unit - (24 Beds)	7	4,799
153	17-028	IL (Pending)	200-Bed NHC (New)	7	18,200
154	47-010	TN (Memphis)	120-Bed NHC, Plus 20-Bed Alzheimer's Unit (New)	7	11,533

Construction Grant Applications for FY 2007

FY 2007 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
			Applications Subject to 38 CFR 59 Priority Groups 2-7 (continued)		
155	27-035	MN (Willmar)	90-Bed NHC (New)	7	11,765
156	32-003	NV (Reno)	90-Bed NHC (New)	7	30,461
157	18-001	IN (Lafayette)	50-Bed Alzheimer's Unit, Plus 15-Bed NHC Unit	7	7,990
158	21-011	KY (Pending)	160-Bed NHC (New)	7	14,625
159	49-004	UT (St. George)	80-Bed NHC (New)	7	7,373
160	49-005	UT (Lehi)	100-Bed (New)	7	9,004
			Subtotal All Priority Groups 2 - 7 Applications (No State Matching Funds):		317,061
			Total All Pending Applications:		808,391

** These projects were conditionally approved after August 15, 2006. This provides a 180-day time extension authorized in 38 UCS 8135.

** P This California project was conditionally approved for a partial grant after August 15, 2006. This provides a 180-day time extension authorized in 38 UCS 8135. In accordance with 38 CFR 59.50(b), this project is ranked # 1 and also at # 24. Under the # 1 ranking, the conditionally approved partial grant would receive the highest ranking and receive 30 percent of the available funds for FY 2007. The second ranking of the project does not provide any special priority and is ranked in accordance with 38 CFR 59.50.

** 1 The State of Texas requested FY 2007 funding consideration for two bed-producing projects (FAI 48-008 and FAI 48-009). Projects FAI 48-010 and FAI 48-011 have PG-1 certification of 35% State matching funds.

These applications will be funded in FY 2007 in the order which they appear on this list, subject to the availability of Federal funds and compliance with all Federal requirements. Conditionally approved projects have been ranked and will be awarded grants subject to meeting the remaining Federal requirements.

Approved.

9/29/06

R. James Nicholson
Secretary, Department of Veterans Affairs

Date