

**AN ABIDING COMMITMENT
TO THOSE WHO SERVED: EXAMINING VETERANS'
ACCESS TO LONG TERM CARE**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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JUNE 7, 2023
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WEDNESDAY, JUNE 7, 2023

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

The Committee met, pursuant to notice, at 3:12 p.m., in Room SR-418, Russell Senate Office Building, Hon. Sherrod Brown presiding.

Present: Senators Tester, Brown, Blumenthal, Hirono, Sinema, Hassan, King, Moran, Cassidy, and Cramer.

SENATOR SHERROD BROWN

Senator BROWN [presiding]. The Senate Veterans' Affairs Committee will come to order. I am not Jon Tester, as probably most of you know. He will be here shortly. I will just introduce the witnesses. I will make no statement, but I will introduce the witnesses, and you can proceed; let us do that.

First of all, I would like to welcome Dr. Christopher Saslo, Chief Nursing Officer and Assistant Under Secretary for Health for Patient Care Services at the Department of Veterans Affairs.

Welcome, Dr. Saslo.

He is accompanied by Dr. Scotte Hartronft, Executive Director of VA's Office of Geriatrics and Extended Care.

Dr. Saslo will be followed by Jonathan Blum, Principal Deputy Administrator and Chief Operating Officer at CMS, an agency at the Department of Health and Human Services.

Mr. Blum, thank you for your work some years ago when we first had discussions about these such things.

So, Dr. Saslo, the floor is yours. Please proceed.

PANEL I

**STATEMENT OF M. CHRISTOPHER SASLO
ACCOMPANIED BY SCOTTE R. HARTRONFT**

Mr. SASLO. Thank you, Senator Brown. Good afternoon, and thank you, Senator Brown and other distinguished members of the Committee. We appreciate the opportunity to discuss our veterans' access to long-term care in both institutional and non-institutional settings. I am accompanied today by Dr. Scotte Hartronft, Executive Director for the Office of Geriatrics and Extended Care.

The older population in America is growing. For the first time in U.S. history, adults over the age of 65 are on pace to outnumber children under the age of 18 by the year 2034.

As veterans age, approximately 80 percent will develop the need for long-term services and support. Our top efforts focus on supporting our veterans' care with a spectrum of home- and community-based services. These programs provide care and support for veterans ranging from needs in the home to inpatient and long-term care.

We know that 90 percent of Americans would prefer to age in place, in their home or in the least restrictive settings that are possible, as long as it is safe to do so. VA supports veterans' expressed desire to remain in their homes for as long as possible. To support this, VA provides and purchases an array of services and programs from qualified providers. In fiscal year 2022, VA served more than 400,000 unique veterans and spent \$3.9 billion on home- and community-based care.

VA provides and purchases an array of services and programs from qualified providers throughout the Community Care Network, our contracts, as well as Veterans Care Agreements. VHA has a large portfolio of programs to support aging in place, ranging from in-home assistance to assist with bathing and dressing all the way to licensed VHA clinicians providing primary care in the veteran's home. If a veteran is unable to safely remain at home, VHA has innovative models to allow veterans to honor their preferences for care, such as our Medical Foster Home.

Additional details on the multitude of programs VHA provides can be found in the written testimony.

When options for living at home are no longer feasible for a veteran's care, VA can offer veterans care in a nursing home setting in which skilled nursing care along with other supportive medical care services are available. All of our veterans receiving nursing home care throughout the VA, whether provided in one of the 134 VA nursing—VA-operated Community Living Centers or purchased by contract in a Community Nursing Home, are available.

Veterans can also choose to receive nursing home care at one of the 163 state-owned State Veterans Homes across the country that VA maintains partnership with. VA provides quality oversight of the State Veterans Homes and provides per diem payments for veterans' care throughout the SVH Grant Per Diem program.

VA has already embarked on an accelerated rollout of the Veteran-Directed Care program. All VA medical centers will have operating programs within the next two years.

We are also adding 75 home-based primary care teams, targeting the expansion to VA medical centers with the highest unmet need, such as in our highly rural sites.

By the end of fiscal year 2026, all VA medical centers are required to have a Medical Foster Home program.

Also, we are piloting a new model of Homemaker/Home Health Aide services where the services are being provided by VA staff and not community agencies.

In conclusion, VA's various long-term care programs provide a continuum of services for older veterans designed to meet their needs as they change over time. Together, they have significantly

improved the care and the well-being of our veterans, even during times of crisis. These gains would not have been possible without the consistent congressional commitment in the form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing the high quality care for our Nation's veterans and their families.

Senator Brown, other members, this concludes my testimony, and my colleagues and I are prepared to answer any questions.

[The prepared statement of Mr. Saslo appears on page 41 of the Appendix.]

STATEMENT OF JONATHAN BLUM

Mr. BLUM. Senator Brown, Senator Blumenthal, thank you for the opportunity to be here today.

Today, CMS certifies more than 15,000 nursing homes throughout the country that serve more than 1 million people on a daily basis. That includes veterans. CMS feels that one of our core missions is to ensure the safety of the care for all nursing home residents. My goal today really is to summarize what CMS wants to do, plans to do to improve nursing home quality.

In 2020, when the pandemic first hit this country, too many nursing homes were not prepared to contain the pandemic. Too many residents died. The system failed too many. CMS rules, CMS guidance were not established to adequately ensure the overall safety of nursing home residents, the staffs, and their families.

But the good news is the system quickly changed through the hard work of nursing homes, their staffs, through better rules, through better guidance, through better technical support, through better data reporting. Nursing home residents are far safer today. We should never again see the death, see the despair that we saw during 2020.

This really is a phenomenal chance now going forward for us to change the focus and really think differently for how CMS certifies, how CMS oversees, and CMS thinks about the overall safety of care. And to that end, the President directed us during 2022 through a 28-point plan to change our policies, to change our guidance, to change our operations, to really take bold but necessary steps, and to this end we have worked diligently to put that plan into place.

We have changed how we survey. We have better survey processes going forward. We have changed enforcement. We have more timely enforcement going forward. We have changed how we think about transparency, putting out more quality data, putting out nursing home data regarding the ownership to give residents and their families better information for how they choose their care. We are working toward building stronger staffing standards because we know that when nursing homes have sufficient staff they have better quality outcomes. And, we are working with the Congress to ensure that we have the adequate resources to ensure that CMS can do its work well.

When fully put into place, we believe strongly this plan will boost the overall quality of care and to improve access. This will bring

more accountability to our programs and bring more workers back to nursing homes.

The best way, we think, to ensure high quality and good access is to ensure we have sufficient staff for all nursing homes. Patients tell us this, residents tell us this, the staff tell us this, and data tells us this. During these past two years, we have spent a whole lot of time to talk to residents, talk to the caregivers, talk to staffs, talk to operators, and the one thing they say to us consistently is that more staff, better staff will ensure better quality outcomes and will ensure safety and keep facilities open.

I have personally traveled to many parts of the country during the past two years and have seen firsthand nursing home care being provided in large urban areas and small rural areas and in frontier areas. We know that no one-size-fits-all can serve the country well, but we also know that we have great urgency to this work.

But we pledge, CMS pledges, to work in full partnership here with the Congress, with all stakeholders to ensure that we can better serve residents going forward and better serve the public going forward.

With that, we will yield back time and take any questions you may have.

[The prepared statement of Mr. Blum appears on page 48 of the Appendix.]

Senator BROWN. Thank you, Mr. Blum.

Let me start with Dr. Hartronft. I appreciate your being here. My state has 350,000 veterans over the age of 65, slightly more than a third of the veterans in our state.

Dr. Saslo said in his testimony 80 percent of veterans will need long-term services and support at some point in their life. Of course, veterans, like all Americans, would prefer to remain in their homes and receive care there. We know it produces better outcomes and improves quality of life. Veterans should have that option, of course.

I am glad to see President Biden's Executive order for increasing access to high quality care and supporting caregivers, including considering a pilot program for a new co-employer option, I believe is the term, and provide veterans with a choice to direct their own care.

So, Dr. Hartronft, if you would, what are your plans for implementing a pilot program offering veterans that choice? Can you give some insights on the scale of the project and on the scale of the pilot project? How many of us—I know many of us would like to see that program offered to as many veterans as possible.

Dr. HARTRONFT. Yes, sir. Thank you for the question. Our office is working closely with the VA Innovation Center to determine feasibility at this time, including determining the process and payment, use of authorities, and other means that we will be able to implement, as well as the best sites and states will be determined and any additional resources needed for implementation.

We think the feasibility stage will be completed in August 2023. So we are in that feasibility stage, too, because the CEO model is kind of a broad umbrella and we are looking for a specific model that fits under there, and this ideally will fit somewhere between

our current programs of Home Health Aide, which is agency-provided versus the Veteran-Directed Care, which is the veteran chooses their providers. So this will be a hybrid between what we already have, just again to find out does this model, potential model, work better for certain veterans than other programs that we already have.

Senator BROWN. Thank you.

Dr. Saslo, I have done as I have said in this Committee, talked to the Chair, the author of the PACT Act about it, and we have worked on a lot of that together. And I have done some 30-plus roundtables in about half the counties in Ohio, and I hear often about the quality of VA care. And certainly people come to complain, but most people are pleased with what the VA does and are proud to be in that system.

We know that the VA provides some of the highest quality of specialized care for veterans with spinal injuries and disorders. In Ohio, we have several VAs and more than two dozen community-based clinics, but we have only one spinal cord injury and disorder care center. That is in Cleveland. It is one of 25 such hubs nationwide. What steps is the VA taking to ensure that veterans served at that facility have the necessary access to long-term support and services for spinal cord injuries and spinal cord disorders, Dr. Saslo?

Mr. SASLO. So, thank you for the question. One of the things that I think is probably a best example is VA continues to look at the different staffing models within the areas that are needed. Spinal cord injury, long-term care, et cetera, are several of the types of staffing methodologies that we look at, not only on an annual basis to see what the services are best to serve that population, but also how we need to change the model based upon the staffing mix within the area of need. So I think for VHA as a whole one of the things that we are extremely committed to is making sure that the models themselves that are requiring additional staffing or changes to staffing are opportunities that we look at on a regular basis.

And I will turn to Hartronft in case he has any additional information.

Dr. HARTRONFT. Yes. And with those hubs, then we also have spokes that go out to each of the other sites on a main hub. And then with the SCI veterans, they also have their annual evaluations as well as have a specialty team that takes care of their care. So part of that is again their group that kind of helps care-coordinate for them and would know the resources best available for them in their community.

Senator BROWN. Thank you. Last question, and I will turn to Chair Tester.

Mr. Blum, it is important we make sure veterans who choose to live in nursing homes are living in safe, high quality facilities. The President's budget requested an increase to survey and certification funding for fiscal year '24. Explain why an increase in that funding is important.

I know that Chair Tester in this Committee has always fought for veterans' increased funding as the Administration has. Talk that through for a moment.

Mr. BLUM. Well, I think for CMS, for the past eight years, we have had the same budget, a flat budget, for how we can fund survey and certification work. That constrains resources. That means that states that carry out this work do not have funds to plan for how to hire staff. And what we hear from staff—from states is they are losing staff to do this important work. So we believe in order for us to move forward well, to do sufficient surveys, to really ensure safety throughout the country, to give the states the funds they need in order to carry out this work, that the budget has to grow.

So the overall constraint is that we have been flat-lined for the past eight years. We have more demands. We have more complicated situations. So we need those funds to grow to ensure that we can fund states, we can fund CMS to carry out this important work.

Senator BROWN. Thank you.

CHAIRMAN JON TESTER

Chairman TESTER [presiding]. Thank you, Senator Brown.

I would just ask that my opening statement—in unanimous consent, my opening statement be put in the record; hearing none, so be it.

[The opening statement of Chairman Tester appears on page 37 of the Appendix.]

Chairman TESTER. Senator Blumenthal, you may proceed.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you so much, Mr. Chairman. Thank you, Senator Brown. And, thank you all for being here today on a subject that is so important to our veterans.

I want to talk about one specific area that is important to nursing homes, which is the shortage of nurses, and we have talked about this issue with other representatives of the VA. I know that you have been working on it. You can talk a little bit about what is being done and what more can be done to train, recruit, incentivize nurses, who are so critical, do so much thankless work, and should be supported and elevated rather than taken for granted.

Mr. SASLO. Thank you for the question, Senator Blumenthal. I am actually really proud to say that VHA really has leaned in significantly on our efforts to strengthen the workforce. Our Office of Nursing Service actually has several different pillars that are looking at ways that we can engage, grow, and sustain our nursing workforce.

We have increased the number of our registered nurse—RN transition programs. We are also looking at different models of training our nursing assistants so that we have an in-house opportunity to actually grow the best type of staff that we need to be able to ensure the care that our veterans receive.

We also have made sure that all of our medical centers are aware of the different hiring and recruitment and retention authorities that are available to them. We have significant numbers of recruitment and retention authorities that we have put in place,

and we have been given support by both the Secretary and the Under Secretary to really be as flexible with those authorities as possible, ensuring that we are reaching out to our population of potential candidates as well as sustaining the existing population of nursing staff that we have.

So it is important for us to make sure that the individuals that we have already hired and have in place in our environments and in our settings really want to stay there as well as being able to recruit the best and the brightest talent in the future. We have approximately 15,000 positions that we need to fill each year to sustain the nursing workforce, and so we are looking at every potential option in order to make sure that we are growing it.

As I mentioned in my earlier statement, the staffing methodology that we use really is one of the key elements that tells us how much staff across the entire enterprise, whether it is in long-term care, acute care, or even in the mental health arena. So we really are very proud of the steps that our Office of Nursing Service has taken in moving that forward.

Senator BLUMENTHAL. I recently joined a number of colleagues in supporting legislation. I believe it is known colloquially as the Dole Act. Both parties actually joined in supporting this bill in this Committee. Unfortunately, it was blocked from passage. I am hoping that maybe my Republican colleagues this time around will join in supporting it. It would expand access to home- and community-based care programs for veterans.

Can you explain how this measure would improve the lives of veterans across the country?

Mr. SASLO. So our current plan, as I mentioned in my opening statement, really is to expand the home-based primary care opportunities, making sure that we have that in the most rural settings. I think one of the key elements is that it is a multidisciplinary approach that we are looking to make sure is available. So it is not just our nursing staff but our clinicians as well as all of the ancillary support that goes with it.

And I will ask Dr. Hartronft if he would like to expand on that just a little bit.

Dr. HARTRONFT. Yes, as you know, the Senator Elizabeth Dole bill has many components to it, but with the staffing model, I think especially workforce, it will give us some—you know, working with the Department of Labor and others to see—because it is not only a VA problem, obviously. So we need to work with subject matter experts in the labor market as well as trying to figure out how we can work together to really increase the field of direct care providers and others.

Senator BLUMENTHAL. Thank you very much. My time is expired, but again, thank you, and I hope that we continue to work together on these issues.

Thanks, Mr. Chairman.

Chairman TESTER. Senator Cramer.

SENATOR KEVIN CRAMER

Senator CRAMER. Thank you, Mr. Chairman. Thank you, gentlemen, for being here and for your service.

For the two VA witnesses, just right up front, North Dakota is like a lot of rural states. We have a lot of nursing facilities throughout the state, some with a lot of beds available, high quality, and they want to serve more veterans. They truly want to serve more veterans, but it is a clumsy relationship. The contracting is complicated. Getting paid is complicated. I mean, can we simplify this for our veterans so that our nursing homes can do what they want to do, and that is serve them?

Is that too simple a question? I am just teeing it up for you. But it is a real concern. I mean, it is a real issue that we hear a lot about back home.

Mr. SASLO. Thank you, Senator Cramer. And I truly do agree that we want to maximize the efficiencies, our ability to engage not only our Community Nursing Homes but the long-term care settings that are within the VA itself. And so knowing the challenges that we have had with staffing, both in the private sector as well as in the VA, one of our goals is to really make sure that we can maximize any of the efficiencies when it comes to contracting and placement, knowing that we need to maintain the expectations of what we are allowed to do through our authorities.

Dr. Hartronft, do you want to add—

Dr. HARTRONFT. Yes. And especially now that we are—there is some flexibility among the different—whether they want to do the typical local contract versus the Veterans Choice Agreement or Veterans Care Agreement versus the Community Care Network. So each has a particular new fit, potentially better for one facility than the other, but I think part of it is letting facilities that feel that the typical contract process is too tedious—by all means, we should be talking with them about the Veterans Care Agreements and other avenues that might be better for them and their particular needs.

Senator CRAMER. Yes, no. I mean, that is well said, but we already threw out all the options. At least, you mentioned flexibility. Flexibility is important. Now you can look at the various programs that can fit and then look at the localized situation and do the right thing.

I just worry, and I just see it, you know, in every bureaucracy, but it is particularly difficult to watch in the VA bureaucracy where a veteran is not getting served that wants to be served and has people that want to serve that veteran and just some bureaucratic nonsense is getting in the way.

And I am not blaming you for it. I am just saying, gosh, let us simplify complicated things and not complicate simple things. And I know you are committed to that, and we want to continue to work with you on it.

Mr. Blum, I want to talk a little bit specifically about the staffing challenges. Right? I mean, I hear it everywhere. It is not new. It is not new to this industry. It is every industry, but it is particularly problematic, obviously, in health care.

Mr. BLUM. Yep.

Senator CRAMER. And I have worried a lot about the use of contract nurses, and yet, when you need workers, you need workers. Right? All of that stuff.

And I am a little concerned about the talk of staffing ratio mandates and the impact that would have on an already very stressed situation. You know? So how does that policy help I guess is the bottom line, and can we please change it or drop it or admit we were wrong or something?

Mr. BLUM. Thank you, Senator, for the question. We are still in the process of thinking through what is the best policy for how to think about staffing requirements going forward. One of the things that we see clearly in our data is that those facilities that have more consistent staff, more stable staff, they have higher quality outcomes. I was traveling throughout the country this year and just saw firsthand if facilities can retain staff and attract staff they have high quality outcomes and they have better satisfaction from their residents.

What we want to see is a clear signal to the industry for how they build programs, how they build connections. We are seeing a lot of nursing homes build strong ties to their local high schools, their community colleges, their colleges to train the next generation of health care workers, nursing home workers. So our view is with a clear signal that is carefully put together we will build the workforce that we need over time to best serve Medicare, Medicaid, and all residents for our country.

Senator CRAMER. Well, I do not think you have too much of a survey to conclude what your data demonstrated. The question is: How do we get there? I love all your suggestions, working with local schools, introducing young people to the joys of long-term care work, but I am not sure mandating ratios is going to get us there. But, with that, I appreciate all your attention.

Thank you, Mr. Chairman.

Chairman TESTER. Thank you for the question. I will follow up when I do mine, too, Senator Cramer.

Senator King.

SENATOR ANGUS S. KING, JR.

Senator KING. I want to follow up on the staffing question.

I mean, we have got enormous staffing problems, and to say you have got to have a certain—it seems to me that opens up liability questions and it puts the staff under a lot of strain because it is just unrealistic right now.

Mr. Blum?

Mr. BLUM. But in this—

Senator KING. I understand it would be better, absolutely, but you cannot conjure people out of thin air.

Mr. BLUM. One of the things that we are seeing and experiencing in our data, but also seeing in our travels, is that we are seeing a stronger workforce than we had two years ago. We are seeing fewer contract dollars, fewer traveling nurses, fewer traveling physicians due to just a more stable workforce, and so we want to build upon that.

And the challenge for us is that we see clearly in our data that when nursing homes do not meet set standards, minimum standards, the quality of care is horrible, that harm happens.

So our goal is to really find the right balance between making sure the nursing homes can fulfill the requirements to the Medi-

care and Medicaid programs, they can have a growing staff, but we see the best solution to this tension of better quality outcomes and better access through a growth and consistent staff.

So our goal is to send a very clear signal, again back to nursing homes, to say: This is what is required to meet basic Medicare and Medicaid requirements. And if we do not have that, we are going to see less access, we are going to see more facilities close, we are going to see worse quality outcomes.

Senator KING. And you are going to have fewer beds for veterans to go to.

Mr. BLUM. We believe—

Senator KING. We are not serving veterans if a home closes because they cannot meet the staffing standards because they cannot find the people. Let us get real here.

Mr. BLUM. We believe—

Senator KING. Do not tell me you are improving service to veterans when you just said we are going to see nursing homes close.

Mr. BLUM. We do not think they are going to close.

Senator KING. You just said that. Didn't he say—didn't he use the word "close?" Yes, you did.

Mr. BLUM. That was misspoken. What we want to see is a nursing home force that is more stable, that allows nursing homes to continue to—

Senator KING. Nobody disagrees with that. The question is: How do we get there, and are we in the process of getting there setting unrealistic standards that will in fact lead to nursing home closures? That is the issue that I think has to be—you have to address.

It is not enough to say we are going to have a good staff and we are going to have enough staff. I want to hear how you are going to make that happen because we are losing nursing homes generally in Maine because of a lack of staff. And so let us have some programs to retain—raises, training, career ladder, whatever it is going to take—but that is what I want to hear.

And to start with what I believe may be unrealistic standards seems to me is backward. We should start with the programs to build the staff and maintain the staff that we have, then talk about increasing.

Dr. Hartronft, I have known physicians at VA facilities who have left. They are dedicated to the mission. They love the veterans. They say, I have become—all I am doing is paperwork. I want to be a doctor.

How do we relieve that issue? How do we—I am sorry, I am looking at you but talking to you.

You understand. You are a physician. These people want to treat veterans. They do not want to do paperwork. How do we resolve that? And I know people who have left the VA because of that issue.

Dr. HARTRONFT. Thank you, sir. A lot of that is around especially our primary care teams, the primary line care teams, and a lot of it is we have guidelines now as to kind of staffing of ancillary staff trying to help assist with that. So I think part—

Senator KING. I hope that is a focus because I think we cannot lose these wonderful physicians.

Final question. And I realize this has been discussed. We really need to talk about beefing up home care. I once was—I used to travel the state when I was Governor, with our Human Services, and we would be with seniors and elderly folks. How many want to go to a nursing home? No hands went up. People want to stay in their homes, and also, it is a lot cheaper. It is a lot more cost effective.

Describe to me the VA's home care emphasis. And I know there is a pilot program of which Maine is participating, the RECAP program. Talk to me about home care as an alternative to nursing homes.

Dr. HARTRONFT. Specifically, the RECAP program is the Redefining Elder Care in America Pilot. And what we are doing is piloting using predictive analytics to actually determine from all Medicare and VA records as to who is at the highest risk for nursing home placement in the next two years, and we embed a care coordinator who works with their primary care provider to proactively reach out to the veteran and their caregiver to see if they need home services because we can see—

Senator KING. Because every day you can keep a veteran in their home they are happier and the system is saving money.

Dr. HARTRONFT. Yes, sir.

Senator KING. I take it that is—

Dr. HARTRONFT. Yes, sir.

Senator KING [continuing]. Part of what this project is all about. Has it been going long enough to have any results? The RECAP pilot.

Dr. HARTRONFT. The initial results we have not gotten large enough in to really do anything publishable, but at this point we have definitely seen people who are happy with the program, great feedback, and we have seen that if you look at the pre and post with the number of those receiving home care services that has significantly increased after that as an intervention.

Senator KING. Good. Thank you. Please keep us informed on that.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Cassidy.

SENATOR BILL CASSIDY

Senator CASSIDY. I will begin with an opening statement which I have been asked to give on behalf of Senator Moran.

First, thank you, Mr. Chairman. Thanks to the witnesses for being here to discuss how to ensure veterans have access to the long-term care and support they need.

As our veterans sacrificed for us, so we owe them to work to identify the gaps in care and find ways to improve the experience they receive when they work with VA to fulfill their long-term care needs. Access to quality long-term care is an important part of honoring our commitment to our veterans, an issue that affects the veteran, their families, the caregiver, and the community around them.

I once got a call from an old high school girlfriend who just told me her father was in a nursing home, a veterans' nursing home, and the frank abuse that she thought he was receiving. I have no

doubt he was combative. I have no doubt he was combative, but that is one of the issues with taking care of people who are older. And he was transferred to another nursing home, and it went really well.

So I just use the anecdote because it is one thing to read the statement but it is another thing to think of the individual patient. So it is an issue that affects a veteran, their families, the caregiver, and the community around them.

I am interested in how do we improve the coordination between the VA, the community provider, and other stakeholders so the veteran and their families do not have to struggle to access the support they earned. I say that because she—going back to my high school girlfriend, the only way she got help was the fact that her high school boyfriend happened to be a U.S. Senator. Now it should not take a bad relationship for her in high school to finally pay off 45 years later and how much the other person who had a different life experience.

So I say that because we can all recognize as the population of aging of disabled veterans increases the VA will need to ensure high quality and adequate staffing for VA medical facilities, clinics, and Community Living Centers while also expanding its footprint in the community.

I, we, support the VA's efforts to honor veterans' preferences for when, where, and how they receive long-term care. The veteran and the veteran's family should have ultimate control over their health care decisions for the VA.

We must also focus on caregiver support and recognize the vital role caregivers play in the well-being of a veteran. We must provide these caregivers with the necessary resources, training, and support to ensure they deliver the best care. Our hope is that your testimony will help us figure out how to do so, and I thank you for this.

Let us honor our veterans' service and sacrifice by making sure they get the best care we can give them.

Senator CASSIDY. With that, Mr. Chairman, I will then go to my questions. Okay. I gave you an example of a woman I know whose father had one experience in which she alleged abuse and the other in which this same person, same family member, I guess proving that she is not entirely unreasonable, had an excellent experience.

So I understand now this is a veterans-run hospital, so I guess I have two sets of questions here. CMS and VA both provide oversight into these different settings of care; that is correct. To what degree do you communicate if one has a problem, then the other can follow up on the same problem if their visit is intermittent?

Mr. SASLO. So several of the things—and thank you for the question, Senator Cassidy. The aspect of care coordination is really one of the things that we have been looking at maximizing or increasing the effectiveness when we have our veterans that are either within VHA—

Senator CASSIDY. Now when you say “care coordination,” I think of care coordination as a nursing plan, a care plan, but I think in the context of this question you mean: Okay, we have looked at this particular facility. They are doing well. They are doing poorly. By the way, HHS, you are coming in after me, and state agency, you

are coming after me again. You need to watch out for this, or you need to look for that.

Mr. SASLO. So there are several levels when we look at the care that is being delivered in our Community Nursing Homes. And I will ask Dr. Hartronft if he would like to expand on the aspects of how we look at the evaluation, the quality of care, and then how we communicate and partner with our CMS partners in order to make sure that—

Senator CASSIDY. I am less concerned about the particulars of how you look at it because I trust that you are looking at clinically significant things. What I am more concerned about is that if there is a problem that there is communication between agencies, and I think this is more of a yes or no, it occurs, as opposed to elucidating the process because obviously you want a warm handshake.

Listen, we think that their restraint policy is being used too often and too indiscriminately. When you are going to be there in two months, will you be sure to look at their restraint policy?

You see where I am going with that, using a particular example as opposed to a process.

Mr. SASLO. I will ask Dr. Hartronft to expand, but—I think that there are steps that we do have in place, but I will ask Dr. Hartronft.

Senator CASSIDY. And that is to communicate with other agencies with jurisdiction?

Mr. SASLO. Yes.

Dr. HARTRONFT. Yes, sir. Many times, whenever we do our site visits, which are every 45 days in a contract nursing home—they do an onsite visit. And if they do find something at a level, they contact either the CMS directly to do, you know, a for-cause concern or they talk with an ombudsman. And then also vice versa, whenever we are doing our any kind of oversight, we manage what CMS—we pull up the latest CMS survey just so that we are aware when our folks go in there what they were already aware of in their last survey so that we—

Senator CASSIDY. So then that is wonderful. Let me ask you this: Just knowing that there is always a spectrum of quality, I suspect that there are some nursing homes that really you could do them twice yearly, even once yearly, and they are going to be pristine, and there are others that 45 days is probably not often enough, at least until they come under corrective action.

Dr. HARTRONFT. Yes, sir. Especially like with the one-star facilities, not only do they have the baseline 45-day visit to every—

Senator CASSIDY. So one-star is worse quality?

Dr. HARTRONFT. Yes, sir.

Senator CASSIDY. And four-star is best?

Dr. HARTRONFT. Five-star.

Senator CASSIDY. Okay.

Dr. HARTRONFT. And so for the one-stars, based on the quality level, there is—the foundation for all is that every 45-day visit and then an annual assessment. With the one-star facilities, it even includes a waiver that has to be approved by the local facility director and the network director to justify why was that facility chosen over others, and usually it might be the only facility available or

the best choice. It has different levels of scrutiny based on the levels and findings.

And then our staff can also do anytime of ad hoc kind of site visits, and they have an oversight committee at each of the local VAs as well as what we do on a national level.

Senator CASSIDY. Is there ever—I mean, I presume so, but I am just asking for the record. Can a facility be so bad that it is busted and never again can a veteran be allowed to be kept there?

Dr. HARTRONFT. Yes, there has been times where we actually go in and meet with these veterans to make arrangements for them to be placed other—you know, go to other facilities if it gets to that point with a quality concern level.

Senator CASSIDY. Okay, good. Mr. Blum, would you add anything?

Mr. BLUM. Just to add that, by law, we have to survey every certified nursing home roughly every 12 months, but our teams also respond to complaints. And so as we get complaints, whether from the VA or any other entity, that is going to drive more action to ensure that we can ensure safety.

So our goal is to really shift resources to where we have the most challenge, and that is based upon strong partnership; that is based upon looking at complaint data. But the goal that we have is to ensure that, one, complying with the law, that every nursing home gets surveyed roughly every year, but also that we can target resources where we see that lowest quality of care.

Senator CASSIDY. And so let me finish by asking this: Just going back to the anecdote I gave, which was a little amusing but it is a real-life anecdote, if somebody has a complaint to make, they feel as if their loved one is not being cared for correctly—when I go into nursing homes—and I occasionally go in and visit, and the ones I go into are uniformly wonderful. But I never see anything saying, if you have a complaint, call 1-800 file your complaint sort of thing, or if it is a VA patient, if your loved one is a veteran, et cetera. Is that required to be posted, or how would somebody know that? Because I am just struck that again the woman I knew I do not think she knew how to make that complaint and she is an RN and all this other stuff.

Mr. BLUM. Patients served by CMS programs have the right to complain and contact their state process, but there are procedures that we can follow up on to describe how patients can complain.

Senator CASSIDY. But how would she know of this? Would she just have to have the wherewithal to say, it must be on the internet someplace?

Mr. BLUM. No. All residents have their rights to complain.

Senator CASSIDY. But I do not know that notification process. Now I do want to know the process. Would she have to go to the nursing director and say, I would like to make a complaint to HHS?

Mr. BLUM. That is one route that she can take.

Senator CASSIDY. That seems actually unlikely to occur to many people.

Mr. BLUM. We will get back to you, Senator, with a real clear description for how patients can follow up their rights.

Senator CASSIDY. And is there a separate process for a veteran who is being covered by the VA to make a complaint?

Dr. HARTRONFT. Yes, sir. Again, during those every 45-day visits, an in-person social worker or nurse actually interviews the veteran in private and allows them—

Senator CASSIDY. Now if a veteran has dementia, though, which many of these would, that would not be of help.

Dr. HARTRONFT. I am sorry, sir?

Senator CASSIDY. If the veteran has dementia—

Dr. HARTRONFT. Yes, sir.

Senator CASSIDY [continuing]. That would not be of help.

Dr. HARTRONFT. Yes, they make themselves available to caregivers if they are available, or they know that they are coming, then they can reach out. If they—if the caregiver were to be interested to visit with them, they can leave a note with the nurse to give them a call whenever our people are there and they can call them back.

Senator CASSIDY. So I guess my—not to beat it, but just to ask, how would the family member know that I can speak to the social worker of my loved one to make a complaint about—do you see what I am saying?

Dr. HARTRONFT. Yes, sir.

Senator CASSIDY. How would she know that you were going to make your 45-day visit and she could be there in order to speak to the 45-day visit?

Dr. HARTRONFT. Yes, sir. Again, usually, we—they know that they will be coming and—but I think it is something we can improve.

Senator CASSIDY. Okay. Well, thank you. I yield.

Mr. SASLO. If I could just add, Senator, I think one of the other pieces that we try to make sure is a consistent process and when a veteran is placed that that social worker is actually reaching out up front, engaging with the family, the caregiver so that they understand what the expectations are, so that that 45-day visit that Dr. Hartronft explained is something that they should be made aware of up front.

Now the opportunity always exists for us to be able to reinforce when something is not going well for families to be able to have the correct number, have the correct person to reach out to. So we can certainly take that and look at opportunities for improvement.

Senator CASSIDY. Thank you.

Mr. SASLO. Yes, sir.

Chairman TESTER. Thank you for your questions, Senator Cassidy.

I would just follow up for a second in that if you got a situation you cannot expect the loved ones to know how to do this. And I think the social worker reaching out is good on the veteran side of things. What happens with the others? Which is not what this Committee is supposed to be about, but the truth is we all have—there ought to be some notifications made by the rest home that talks about what the recourse is, and maybe in fact that is happening, but it should be happening.

The only other question I have—and this goes along with Senator Cassidy's question, and that is: Do you guys have, your agencies

have, a mechanism by which if you find something wrong you automatically notify CMS or CMS automatically notifies you if they are in a rest home, that it does not just happen when somebody thinks to notify CMS or somebody thinks to notify the VA, but actually you find a problem, you automatically notify the other?

Dr. HARTRONFT. Yes, sir, that tends to be standard operating procedure, that it directly triggers notification to CMS and State and others whenever there is a significant finding.

Chairman TESTER. All right, on a significant finding. What if it is not a significant finding?

Dr. HARTRONFT. Especially, I think that depends on what is found. I know it sounds funny, but—

Chairman TESTER. Well, the question is we could probably have a conversation on what defines a significant finding.

Dr. HARTRONFT. Yes.

Chairman TESTER. But if it is a problem, I think both should know; that is all.

By the way, I appreciate all three of you being here.

Mr. Blum, this is not to be critical at all, but the staffing ratio issue, which Senator Cassidy and Senator King and probably everybody around this table could talk about, from a CMS standpoint is a big issue, and I think I found a solution. You said, with a stable staff, you have a better outcome, which I agree. What I am hearing on the staffing ratios is you are going to require so many RNs for a facility. That is a different issue. That is an issue that Senator King talked about and Senator Cramer, too.

You come to north central Montana, and nurses are gold. My daughter is one of them. And I would love to have a staffing mandate that would give her a job anywhere she wants to go, but the reality is stable staff is what you need. I am not going to say you do not need any RNs. You certainly do, but stable staff is it.

Now I know you do not have the rule out yet. I know you want higher outcomes. We want higher outcomes. But I think the point Senator King made, that closing down a rest home is not a higher outcome necessarily, okay? Not that there is not times when that needs to happen, but we certainly do not want it to happen just because they have no other choice because they cannot meet the staffing mandate.

Can you take that back to your folks?

Mr. BLUM. Yes, Senator. And we are still in the process to finalize this proposed rule, and we understand that this is a very high interest to many people, and we will be happy to consider the comment.

Chairman TESTER. So for a number of reasons, in Montana, not having anything to do with CMS, we have, I think, lost 11 rest homes. These folks are elderly folks that are being moved to other rest homes, which, as you guys know, a lot of stress, a lot of death. And quite frankly—so we need to try to get ahead of that curve and try to solve the problems that you spoke about without taking the issue apart.

I want to talk to you on the VA side of things, Dr. Saslo. The Veteran-Directed Care program provides veterans the opportunity to receive long-term care services in their homes by providing them

with a budget to hire workers to assist them with certain activities. You are familiar with the program.

On the 18th of April, President Biden released an Executive order which, among other things, directed the VA to consider expanding VDC to all VA medical centers by the end of next year, FY '24. The President also advised the VA develop an information plan for VDC expansion by June '23. Would you give us an update on a project timeline for expanding that program to all VA medical centers?

Mr. SASLO. So, thank you, Senator Tester. Our goal is to actually have the Veteran-Directed Care rolled out to all facilities by the end of FY '24.

Chairman TESTER. Yes.

Mr. SASLO. The expansion—Dr. Hartronft has actually been working with the teams across the country—

Chairman TESTER. Sure.

Mr. SASLO [continuing]. And so I will ask him to give you the actual status right now.

Chairman TESTER. Sure.

Dr. HARTRONFT. Actually, currently, we are on pace to meet the guideline.

Chairman TESTER. Good.

Dr. HARTRONFT. And we have actually even had luck in the territorial sites as well. We have currently had the Commonwealth of the Northern Mariana Islands, and we already have in the works the U.S. Virgin Islands, Guam, American Samoa, as well. So we are on pace, sir.

Chairman TESTER. I appreciate that. Five minutes goes awful fast when you are having fun. I will turn it over to Senator Moran.

SENATOR JERRY MORAN

Senator MORAN. Chairman, thank you, and I thank Senator Cassidy for filling in for me this afternoon.

Let me ask to the VA: Does the Department of Veterans Affairs have adequate authorities and flexibility needed to partner with community long-term care facilities and to providers to provide care to veterans in their communities and potentially reduce the demand on VA-owned and operated CLCs?

Dr. HARTRONFT. Yes, again, sir, we have—of the three authorities, the one that has actually taken off more considerably is the Veterans Choice Agreements or Veterans Care Agreements, the VCAs. Most of the local contracts we call IDIQs, and then we also have the CCNs. So we have agreements for over 8,800 nursing homes in the country. We have veterans in every one of those homes, but we have agreements and coverage for that many.

So we—again, we like to find out which of those three authorities fit best for each of the nursing homes because some find—may not like the aspects or realms of a contract. So we can use the VCA. That may be able to be more low, negotiated a little bit different for them, versus them joining the Community Care Network.

Senator MORAN. What should happen when a small-town nursing home comes to me and says: We would like to care for our veterans in our community, but we have no contract with the VA. What can you do to help us?

Dr. HARTRONFT. I would have them directly contact their local VA and just explain that (a) they are interested because it always helps to have a facility that shows the interest in serving veterans, (b) also they can find out is there an unmet need especially in their area because especially in the rural areas it is always nice to have some redundancy to give veterans better choice, to be closer to their support networks and others. So it is really contacting their local VA to find out how they can do either the contract, the VCA, and joining the Community Care Network.

Senator MORAN. Your authorities preceded the Choice Act. So when you use the word “choice” in one of those three options, it is really not related to the Choice Act, correct?

Dr. HARTRONFT. My apologies, sir.

Senator MORAN. No, no. No, I am just clarifying for myself.

Dr. HARTRONFT. Yes, sir.

Senator MORAN. There was no apology necessary.

Dr. HARTRONFT. Okay.

Senator MORAN. And then following the Choice Act—I do not know whether the Choice Act affected your capabilities to provide care in the community for veterans at a nursing home.

Following that was the MISSION Act. I would like to know if it, which is now operational—does it give you additional authorities, make it easier for a veteran to get nursing home in a community, or unchanged?

Dr. HARTRONFT. I think the VCAs have really helped in that niche between formal contract and our Community—the Community Care Network is even relatively new for us. So that added over, you know, 6,000, I think, sites just by joining the CCN. So, yes, I think with adding the VCA, if a facility is not interested in a traditional contract, then we are able to ask them and explain a VCA to see if that fits their needs. And many of them—that is where more of our growth here recently has started to become.

Senator MORAN. Would you assure me that there are no particular biases in the VA toward care within a VA facility versus a veteran who chooses his or her care to occur in a community?

Dr. HARTRONFT. We do not see that on a large scale. We do not have any evidence of that because really our CLCs, our VA-owned CLCs, really serve a different population than many that are served in contract nursing homes and our State Veterans Homes. Many of them are more short-term rehab. There is a two times higher level of PTSD. We have got higher levels of traumatic brain injury and certain diagnoses as well as other issues.

Senator MORAN. So in many instances, they serve a different type of veteran, a veteran with a different circumstance in their lives?

Dr. HARTRONFT. Yes, each program tends to serve veterans differently. If they are more stable, the CNHs, contract nursing homes, help them to get closer to their caregivers and their support versus sometimes our CLCs can also be more of a short-stay rehab or, you know, tune them up or some sort of other rehab-type potential for folks and different populations.

Senator MORAN. And of course, then we have our State homes as well.

Dr. HARTRONFT. Yes, sir.

Senator MORAN. I think there is—it is difficult for families and veterans to determine the long-term care resources that are available to them. One of the provisions that we have included in the Elizabeth Dole Home Care Act is to require the VA to inform veterans and caregivers participating in PCAFC programs their eligibility in other long-term care programs. What is the VA doing now to ensure that veterans and their families are receiving those resources, that information?

Dr. HARTRONFT. I think right now what we have tried to do is to have every veteran that is enrolled in the VA—they and their caregivers can make an appointment with their primary care PACT-assigned social worker because we like to have the provider involved. And that person can then determine what level of care coordination they need, and then they can also let them know their eligibility when it comes to like institutional nursing home care but then also the fact that most of our home care is not eligibility-based or priority-based in the sense of—and then helping them to the next step. So we try to let the social work and care coordination team really serve as kind of the landing spot to help all those folks then figure out where they need to be, and they can be handed off to the right kind of care level.

Senator MORAN. Thank you. I just would encourage you to make sure that the answer you just gave me is true across the country, true in every VISN. It is not an infrequent circumstance in which a witness or someone from the VA conversations that I have with VA officials, this is what our policy is, but not necessarily known or operational in places in Kansas and across the Nation.

Dr. HARTRONFT. Yes, sir, I think we can always improve, and we definitely will take the feedback.

Senator MORAN. Thank you.

Chairman TESTER. Senator Hirono.

SENATOR MAZIE K. HIRONO

Senator HIRONO. Thank you, Mr. Chairman. I know that the United States is experiencing a rapidly aging population. So there is going to be a need for, I would say, a wide range of long-term care facilities. Does the panel agree that we should have flexibility in the kind of facilities that are provided, including the option of community-based long-term care homes?

So in order to do that—because we cannot keep up with continuing to build, for example, veterans' homes that can provide long-term services. We cannot keep up. Hawaii, in fact, is building another 45-bed skilled nursing facility for veterans, and that hardly is going to be adequate for the needs.

So one of the things that I want to mention and talk about is that we in Hawaii often resort to community-based group homes where people, five to six unrelated people, can get the care that they need, and this is not a particular model that the VA reimburses for. So I am wondering whether VA and CMS support the kind of long-term care options for veterans that are more in line with the kind of group home facilities license that we have in Hawaii.

Anybody want to respond?

Mr. SASLO. So, thank you, Senator Hirono. One of the things that I think is akin to what you just discussed is our concept of the Medical Foster Home. And so those types of settings, where we have the availability of individuals who are willing to take our veterans in and provide that long-term care or the type of care that that veteran is specifically in need of, really is one of the things that we continue to move forward with and we continue to expand. I think that we have identified numerous types of levels of care that are specific to a veteran depending upon their need, whether they can still remain in their homes, such as a Veteran-Directed Care opportunity or if they are not ready to go to a nursing home or if a Medical Foster Home is more in line with that.

One of the things I am sure you are aware of is that we are required to expand our Medical Foster Homes—

Senator HIRONO. Yes.

Mr. SASLO [continuing]. And we are also going to be paying for Medical Foster Homes for the veterans, where typically, in the past, the Medical Foster Home was paid for by the veteran individually. So we have lots of opportunities to grow as well as expand other ways to deliver the care the way the veteran wants it.

Mr. BLUM. For CMS, we want to support the care setting that our beneficiaries want to receive, and so we are eager to work with states to support more flexible options. And so the principle that we want to see going forward is that our CMS programs support the care that our beneficiaries want to receive in the setting that they want to receive it.

Senator HIRONO. You want to add something?

Dr. HARTRONFT. Yes, ma'am. Part of it, too, is also letting veterans become aware of other benefits from like the VBA, such as Aid and Attendance, and pensions, and others that can help them finance assisted living and other arrangements. So many times, if we cannot directly pay the room and board in certain situations, then we try and make sure that we have got them streamlined, working with VBA, and we try to help them with that. As well, as Dr. Saslo mentioned, we have got this pilot where we can—especially for certain veterans, we can now actually pay for their room and board as part of the recent bill, and we are going to pilot that.

Senator HIRONO. So I misspoke when I said that we are building a 45-bed—no, we have—I meant to say we have 45 large-scale skilled nursing homes but about 1,200 adult residential care homes in a state like Hawaii, where there is much more support for community-based aging. I do not know whether this is a model that can be utilized in other states, but in Hawaii it is where a lot of our seniors go. And my mother started off in a rather large skilled nursing facility, and then she was moved to a smaller facility where there is much more of the kind of care, the same level, pretty much skilled nursing care.

But it works in Hawaii. So I am wondering whether a lot of our veterans would not be happier not so much in these large facilities but in smaller facilities, and reimbursement is really important in these instances. So I would encourage you all to continue to move in that direction and allow for that kind of treatment experience for our veterans.

Mr. SASLO. Thank you, Senator Hirono.

Senator HIRONO. Thank you.

Mr. SASLO. We will certainly take that back to look at it and explore the opportunities.

Senator HIRONO. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Hirono.

You guys are free. You are welcome to stay. We have got a second panel coming up, folks representing veterans and some of the facilities that care for them.

But I just want to thank all three of you for what you do, appreciate it very much. Thank you for being a part of this hearing.

So with the second panel, we are going to hear from Carl Blake, Executive Director of Paralyzed Veterans of America; we are going to hear from Whitney Bell, who is the President of the National Association of State Veterans Homes.

And, Whitney, I believe you are from North Carolina, correct?

Ms. BELL. Yes.

Chairman TESTER. Yes. And then Carla Wilton, who is the Chief Operating Officer of Immanuel Lutheran Communities in the great State of Montana and the great city of Kalispell.

And so we want to welcome you folks to talk about what is going on, on the ground, with the facilities that you represent and the veterans you represent moving forward.

So, Mr. Blake, you have the floor. It looks like by the clock you got five minutes, but know that your entire statement will be a part of the record.

PANEL II

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman. You have all of the detailed statement that we submitted. I debated what I wanted to discuss today in going over all the different details and different issues that are outlined, but I think I would rather respond to some of what I heard over the first panel, some of the discussion.

Senator Brown said, before you came in, that in Ohio, 80 percent of veterans in that state will eventually need long-term care. I hate to break the news to him, but 100 percent of veterans with spinal cord injury will need long-term services and supports over most all of their life, not just when they age, but from the point of acute injury for the rest of their life. So they may be a 20-year-old with an acute injury; they will need long-term services and supports forever.

So I appreciate the idea that 80 percent of veterans might need it. Our members need it now and all the time.

I heard a comment. I may have misunderstood it, but I thought one of the last comments I heard was about using A and A veterans' benefits to pay for, or offset the cost of, care because the cost for long-term services and supports is high. That is nonsense.

I do not think we should be telling veterans that your earned benefits should be what you use to pay for your care because the VA cannot afford to pay for your care. I am not going to tell our members that. I would dare anyone to say the same thing to any

veteran, that that is what the expectation is because it certainly is not.

There was some discussion here about the feasibility of expanding services, and it was in the context of, I think, Homemaker/Home Health. Our members do not have time to wait for feasibility studies on expanding some of these types of programs.

Long-term services and supports are a reflection of the long continuum of care that our members engage with the VA in. They have an acute injury. They get acute care. They get acute rehab. In most cases, they will transition into the home, receive home- and community-based services and want to live most or all of their life in as independent a fashion as possible. And some of them will eventually end up back in the VA in a long-term care facility that is managed under the SCI system of care because, frankly, Community Nursing Homes and CLCs, those types of things, they do not serve our members. In many cases, they are not even accessible to our members, physically accessible.

And so they run into barriers repeatedly. As you know, we have had conversations with your staff and Senator Moran's staff about the 65 percent cap for home- and community-based services. That is a serious barrier to accessing the care that our members need.

For the actual physical infrastructure of VA, I do not know if the Committee is aware of this, but there are six long-term care specific SCI centers in the entire VA health care system. Six. As of last week, that equated to 160 beds in the entire VA health care system for SCI-specific long-term care. One of those facilities is west of the Mississippi River. One. In Long Beach, California. Two-thirds of the country is served by one single long-term care facility for SCI-specific needs.

There is a footprint being built in Dallas. There is an expansion being done in San Diego. It still will not matter. That is not enough to meet the needs of our members, who will end up there more often than not because that is the complex care that they need and, frankly, the VA delivers it best for our members.

So we hear repeatedly about the challenges of it just costs a lot to do this. We understand that. Our members do not care. We should not be telling them, look, we cannot really afford this right now because it is expensive. That is bullshit. We found a way to get the PACT Act done.

This group of veterans all, universally, need long-term services and supports, and we are telling them we can only do so much because we can only afford so much. This is the core of what the VA does. These are veterans with severe disabilities, who have the highest demand of needs across the entire system, and they are being told, you are probably going to have to wait.

Senator Cramer said something in a little bit different context in his comments earlier. He said—and I think he directed it at the VA and maybe to some degree CMS, and said, we just need to do the right thing. That statement applies to more than VA and CMS. It applies to the people that sit around this dais. It applies to us. Do the right thing.

Our members are tired of political posturing and election-year politics that are standing in the way of much-needed reforms like

the Dole Act, like the CAREERS Act, like the BUILD Act. Just get it done. Do the right thing.

[The prepared statement of Mr. Blake appears on page 72 of the Appendix.]

Chairman TESTER. Appreciate you, Carl, appreciate your passion. And, the message is clear. Thank you.

Whitney.

STATEMENT OF WHITNEY BELL

Ms. BELL. Thank you. Chairman Tester and members of the Committee, as President of the National Association of State Veterans Homes, I am pleased to offer testimony on the role state homes play providing long-term care to veterans, the impact of the pandemic, and how Congress and VA can strengthen state homes to allow us to care for America's heroes.

Mr. Chairman, my full-time job is administrator of the State Veterans Home in Fayetteville, North Carolina. However, today I am pleased to share the combined experiences, observations, and recommendations of my NASVH colleagues.

As you know, the State Veterans Homes program is a partnership between the Federal Government and states that provide long-term residential care to aging and disabled veterans through 163 state homes located in all 50 states and in Puerto Rico. State homes provide half of all Federally supported nursing home care to veterans, and we do so with less than 20 percent of the VA's nursing home budget.

Although states own and operate the homes, VA has wide-ranging oversight authority, performing at least one comprehensive week-long inspection annually. We also have regular and frequent inspections by state and local authorities, and about three-fourths of our homes are also inspected by CMS.

Mr. Chairman, there are an estimated 8.4 million living veterans aged 65 or older, including 1.3 million 85 or older. However, the average number of veterans in VA-supported nursing homes on a daily basis, whether it is VA CLCs, contracted Community Nursing Homes, or State Veterans Homes, is only about 32,000 veterans. That is less than half of 1 percent of the 8.4 million veterans 65 or older, and it is a significant decrease since the onset of the pandemic.

Over the past decade, VA has been placing greater focus and resources on rebalancing institutional and non-institutional care. While NASVH certainly supports providing veterans more home and community options, there should be in addition to, not a subtraction of, facility-based care. The need for traditional nursing home care is neither diminishing nor will it ever go away.

Mr. Chairman, when COVID-19 first emerged, state homes were among the first institutions to take significant precautions. However, the outbreak and spread of COVID-19, particularly its asymptomatic form, made it virtually impossible to prevent any from entering into any facility or location in the country. Despite the precautions we took, including enhanced PPE, suspension of visitation and new admissions, screening of staff and residents, and strict social distancing, tragically, the lack of vaccines, treatments,

and testing made all nursing homes a prime target. And, State Veterans Homes were particularly susceptible because our residents are primarily older men with significant disabilities and comorbidities who, studies show, are more in danger from COVID-19.

As the pandemic stretched from months to years, the impact in our finances has been devastating. To help limit the loss of financial support during the pandemic, Congress authorized temporary waivers from occupancy rates and veteran percentage requirements during the pandemic, but when the public health emergency ended on May 11th, state homes are now losing significant financial support from the VA.

Chairman Tester, we want to thank you and Senator Murkowski for introducing the CHARGE Act, which would reinstate the waiver for bed-hold occupancy requirements, providing a significant financial boost.

My written testimony also includes a number of other policy and legislative recommendations, but I will briefly mention just a couple. First and mostly important, NASVH urges Congress to increase our basic per diem to 50 percent of the cost of care and fully fund the State Home Construction Grant program. NASVH also strongly supports S. 495, the Expanding Veterans' Options for Long-Term Care Act to create assisted living programs for veterans. We thank you, Chairman Tester, and Senator Moran, for introducing this legislation and for including State Veterans Homes.

Mr. Chairman, NASVH looks forward to continuing to work with this Committee to ensure that aging and ill veterans have greater access to a full spectrum of long-term care options, whether at home or in nursing homes.

That concludes my statement, and I will be pleased to answer any questions that you or the Committee may have.

[The prepared statement of Ms. Bell appears on page 80 of the Appendix.]

Chairman TESTER. Well, thank you for making the trek up here to Washington, DC, Whitney, and we appreciate your testimony.

Carla Wilton, you are up.

STATEMENT OF CARLA WILTON

Ms. WILTON. Good afternoon, Chairman Tester and members of the Senate Veterans' Affairs Committee. My name is Carla Wilton. I am the chief operating officer for Immanuel Lutheran Communities in Kalispell. We are a full-service retirement community providing independent living, assisted living, memory support, post-acute therapy services, and long-term care to 300 older Montanans.

I would like to start by thanking you, Chairman Tester, for representing Montana so well and for your advocacy to expand veterans' benefits to assisted living, particularly through Senate Bill 495 that you introduced earlier this year. This important legislation creates a common-sense approach to identifying and securing greater options and opportunities for Montana veterans to access important long-term care services.

In October 2021, we finalized a Community Nursing Home Indefinite Duration Indefinite Quantity contract with the VA. We

typically have about 15 veterans in our building at any one time, and eight of those qualify for the CNH contract. The remaining are eligible for hospice contracts.

Although Immanuel's relationship with the VA has been a positive one, we do have a couple of concerns. The first is the timing of payment, and I think Senator Cramer mentioned that. In fact, just last week, we received our payment from February, March, and April.

Second, when a veteran moves into our community, they change their primary care provider to our medical director, which is fine in terms of their primary care. However, if they need a referral to a specialist, our medical director is not able to order that referral. They have to go back—we have to go back to the VA to get that referral, and that often can be delayed for several weeks, obviously, calling—causing the family and the veteran to have to wait to receive the care that they need.

As you have heard, during the pandemic, nursing homes across the United States lost nearly 250,000 workers. That was 15 percent of our workforce, and we continue to struggle to recruit and rebuild. In Montana, we lost over 1,000 of our 5,500 workers, nearly 20 percent.

Immanuel experienced similar losses of team members during this time. Sometimes we were unable to admit new residents due to our inability to care for them because of our low staffing numbers. We raised staff wages almost 25 percent across the board, and for the first time in our organization's 65-year history, we brought in agency staff. Although this came at great expense, we have a responsibility to provide services to those living on our campus.

While many other health care sectors in the country have recovered, nursing homes still need 190,000 workers to return to pre-pandemic levels. 190,000 staffing challenges in long-term care existed prior to COVID-19, and the pandemic exacerbated them into a full-blown crisis. Caregivers are burned out after fighting the virus. There is a nationwide shortage of nurses, and nursing homes lack the resources to compete for workers due to chronic government underfunding. We would love to hire more nurses and nurse aides, but the people are not there.

Now CMS is planning to release minimum staffing requirements for nursing homes. Increasing staffing requirements at a time when we cannot find the people to fill open positions is a dangerous policy. We need a comprehensive approach to recruit and retain long-term caregivers, not an enforcement approach.

Earlier this year, Chairman Tester led a bipartisan letter to CMS on this very issue, discouraging CMS from taking a one-size-fits-all approach and urging the agency to address the significant workforce shortages affecting rural America. Thank you, Senator Tester and other VA Committee members for signing this important letter.

In Montana, 60 percent of our residents are on Medicaid, and rates have been very low. As a result of decades of low reimbursement combined with the expense of the pandemic and difficulty in recruiting and retaining staff, 11 Montana nursing homes closed in 2022. That is nearly 15 percent of our total nursing homes across

the state. Several of these were in rural communities that only had one nursing home to begin with. It was heartbreaking when residents had to leave their home and move far from family and friends.

These closures brought much focus on Medicaid rates in this year's legislative session. Rates are not finalized, but we anticipate coming out of the session with rates somewhere between 253 and 268. It costs us about \$350 a day to provide care and services to a resident. So although we are grateful for the increase, we will still be losing 80 to 100 dollars per day on our Medicaid residents.

Our current VA contract rate is based on our Medicaid rate. It is about 16 percent plus Medicaid—over Medicaid. When our new Medicaid rate is published, the rate will be somewhere in the high 200s to low 300s, which is getting closer but still falls short.

I understand that the VA also offers Veterans Care Agreements as an alternative to contracts we have. However, those nationally established rates, based on a discount of Medicare, fall below our proposed new Medicaid rates, making it even more difficult for Montana veterans to access Community Nursing Home services.

All residents, including our veterans, are affected by low Medicaid reimbursements, which are set by states with little Federal oversight. We believe CMS should play a greater role in assuring Medicaid rate adequacy and assuring that the rates being paid reflect the reasonable costs. They should do that in keeping with their own regulations and health safety and quality standards.

No one wants better access, more staff, excellent care more than I do. I do this work because I care, but those who pay for the services must also be willing to support the cost of those goals for our veterans and others in our care.

Thank you for the opportunity to testify. I am happy to answer any questions. And if you find yourself in northwest Montana, we would love to give you a tour.

[The prepared statement of Ms. Wilton appears on page 90 of the Appendix.]

Chairman TESTER. Oh, I will, and thank you for the work that you do, Carla.

Ms. WILTON. Yes, thank you.

Chairman TESTER. Thank you.

Senator King.

Senator KING. Thank you, Mr. Chairman. We have been through a long hearing here without the word “dementia” coming up, and it seems to me that that is going to be a growing part of your delivery of services as veterans age.

On January 5th, 2021, not January 6th, but January 5th, the Congress passed a bill requiring reimbursement for domiciliary care. We still do not have the regulations for that. That is a long time ago, over two years. We are going to be—I have a bill to move this process along. Can I have the support of the National Association on this issue?

Ms. BELL. Absolutely. Thank you. We do have states that are affected by that. We are anxiously awaiting what these regulations look like. It has created a small hole in the continuum of care for

veterans with dementia who are not quite ready for skilled nursing.

Senator KING. Exactly.

Ms. BELL. So if that could be under the microscope, it would help a lot.

Senator KING. And when this regulation comes out, the reimbursement should be retroactive to the day of the passage of the legislation. Our veterans should not suffer because of the delay in issuing these regulations. Would you agree?

Ms. BELL. Yes, sir. Yes, sir.

Senator KING. Thank you. One of the most serious problems facing seniors is falls, and one of my problems with our whole sort of reimbursement system is we will pay for a broken hip but it is very complicated to get a grab bar installed in someone's house. There are a number of bills. Senator Casey has some bills on this.

Talk to me about prevention. Isn't that something we should be working on here, Ms. Wilton from Montana?

Ms. WILTON. Yes, I mean, that is a problem, a lot of the problem with our health care system. Right? That we are very reactive. We are responsive when something goes wrong.

Senator KING. We pay for illness, not wellness.

Ms. WILTON. Yes, we pay for—yes, exactly. And so, I mean, in our industry, I think you mentioned two of our highest concerns. You know, falls and dementia happen often in our buildings and cost both our residents and the organizations in terms of staffing and a lot of other things.

So you know, we are looking at all kinds of fall prevention. There is some AI out there that can help anticipate falls. But you know, it all costs money, and like you said, it is hard, too.

Senator KING. But it is penny-wise and pound-foolish.

Ms. WILTON. I know it.

Senator KING. To be not spending \$150 for a grab bar and then pay \$40,000 for a broken hip.

Ms. WILTON. Agreed.

Ms. BELL. Yes, sir.

Senator KING. And there are various programs around falls, but my sense it is not anybody's priority and it is not adequately funded.

Ms. WILTON. Yes, it is hard to get it paid for.

Ms. BELL. Yes.

Senator KING. Thank you.

Mr. Blake, you testified with great passion. Give me again the picture. Your paralyzed veterans, particularly spinal cord injuries, really demand a very high level of care. Are they receiving it now in the VA system?

Mr. BLAKE. I would say the short answer is yes, but that answer has some nuance. I can tell you that veterans that are served directly in the SCI system of care get the best care in the world. There is not a comparable system to that. I think once you start to get out into the community, in terms of acute care, it just does not really exist in that fashion.

In terms of home- and community-based services, I think the answer is yes, they get quality care, but in many cases it is restricted. There are limitations to what they can acquire because of cost, ob-

viously, because of—there was a discussion earlier about staffing. There are challenges with agencies that provide home health support for our members, too.

Senator KING. Right.

Mr. BLAKE. So there is this sort of—there is this web of challenges that make receiving care, when they are home and in the community, more difficult. That is not to say they do not get good care, but they do not always get all of the care they need or when they need it.

For example, I was chatting before the hearing with the folks about one of our members who can only get—he has to get into bed, and he needs home assistance. So I talk to him frequently, and at 7:00 at night he says, I am going to bed now, because that is what he has to get. So he does not live the life that you might live or I might get to live because those are the restrictions that he is forced to contend with because of way the home health system works.

That is a long-winded answer. It is a yes and no answer is the challenge.

Senator KING. I understand. But, thank you for your passion. I want to thank all of you.

I have to leave, Mr. Chairman. I have an appointment with the new Commandant of the Marine Corps, of all people you do not want to leave waiting, the Commandant of the Marine Corps. Thank you, Mr. Chairman.

Chairman TESTER. It is okay.

Ms. Wilton, you noted in your testimony that Montana's Medicaid rates, which the Montana legislature recently voted to raise, although may not be adequate enough, that you are thankful for it. The Governor has not signed the increase yet; you know that. Will it be insufficient to cover the cost of providing nursing home care? You said that that bill produced probably 253 to 268 bucks a day?

Ms. WILTON. Mm-hmm, correct.

Chairman TESTER. And your actual costs were three what?

Ms. WILTON. 350.

Chairman TESTER. 350. Just curious, when the Governor put out a study on what the rates would be, what did that say?

Ms. WILTON. So it said that the rates needed to be a little over 300, but then they took a discount for available beds. They took an occupancy discount, and so they recommended—the study recommended 278.

Chairman TESTER. Yes. So look—and you also pointed out that we have got 11 nursing homes that are closed in Montana, doubtful that those nursing homes will ever reopen again.

Ms. WILTON. No.

Chairman TESTER. And I would say this, that low Medicaid reimbursement rates often leave nursing homes with no choice but to close their doors. You are between a rock and a hard place. And quite honestly, I watched the legislature from afar, thank God, and what I saw was money that was available that they refused to use on it.

I would just say that when these folks are underfunded it impacts everybody, including our veterans. They are left with fewer

options. Loved ones are required to stay in facilities that are a long ways away, and this is not like driving between Washington, DC. and Baltimore. This is like driving a half a day or a full day to get to see these folks. So it is a big problem, so I was a little disappointed in what transpired there.

But can you tell me, as an operator of a 300-people facility that covers soup to nuts, what are the kind of decisions you have to make when those rates for reimbursement are too low to cover the costs?

Ms. WILTON. Yes, it is difficult, and I would say it is not that—this has been going on for decades in Montana, that rates have not been high enough. And so you saw the extreme difficult decision that 11 buildings had to make, right?

Chairman TESTER. Yes.

Ms. WILTON. In fact, I talked to an administrator from the only building that we have in Gallatin County, which is the county that Bozeman sits in, one of the larger counties in Montana. There is one nursing home, about almost 70 beds. And she said that they have been running in the red since 2012 and the only reason they are still open is because it is county-owned and the county has supported it. They passed—the voters passed a levy to keep it open.

I think the difficult decisions we have to make are considering how many residents we can serve with the staff that we can afford to have, and it is a fine balance, right, because you have to have—they say, in our business, occupancy is king. But if you are losing money on every resident, you have to figure out kind of where that sweet spot is, how many residents you can care for and with the staff you can afford.

I think we have to focus more on payer mix than we would like to. You know? We have to like try to manage, you know, our Medicare business and our private pay business to make up for some of the Medicaid business even though it is probably folks that are on Medicaid and veterans that need the service as much or more.

There is tons of buildings across Montana that have lots of deferred maintenance, that have not had any capital dollars to put into maintenance for a really long time. I talked to another—I sit on our Montana Health Care Association Board of Directors. I talked to another administrator from a small rural community, and she said they have not had any capital dollars for at least five years. It is just emergency fixes as things break. She has holes in the floor. The flooring needs to be replaced. The AC does not work, so they have coolers in the corridors.

I think it is a—buildings are having to do ongoing analysis of products to use. You know, maybe have to use a cheaper product even though it does not work as well. In some cases, there is a decrease in services. You might—you know, buildings that provided seven-day transportation, you know, 10 years ago are now providing, you know, four or five days.

I think there is just some small things that we have to let go of. You know, maybe not as many parties with food and decoration, you know, that kind of enhance the day-to-day lives of residents.

And so, you know, I think it is a difficult—it is a really hard business to manage with the increased regulations all the time—

Chairman TESTER. Right.

Ms. WILTON [continuing]. And decreased funding.

Chairman TESTER. So in the previous panel—you listened to it because I saw you.

Ms. WILTON. I listened.

Chairman TESTER. And I would talk to the CMS gentleman, Mr. Blum, about the surveys that they had done about staffing stability, which only makes sense, by the way, if you got the same people coming to work every day—

Ms. WILTON. Totally.

Chairman TESTER [continuing]. Who know the system, and it works better.

But I may have stepped out of bounds. I said, hey, look. The staffing mandate. The problem is really the requirements on our ends. I want you to respond to that. Is that the issue here, or is it just staffing period; you cannot find enough folks?

Ms. WILTON. So nurses and CNAs are difficult also; they are, just especially in communities that have seen such an increase in housing. I do not know how other states have been affected, but Montana has seen huge growth, and housing has gotten really expensive. And so we are—you know, we are starting our CNAs close to \$20 an hour, and you cannot—they cannot afford to rent an apartment.

Chairman TESTER. Right.

Ms. WILTON. And so it is hard to recruit CNAs.

And you know, if you live somewhere—we happen to live in a place that has a lot of summer traffic, and so during the summer we compete heavily with hotels and restaurants—

Chairman TESTER. Sure.

Ms. WILTON [continuing]. In our housekeeping and dining departments.

So you know, I would say it is across the board. You know, it is—yes, yes, it is across the board. Yes.

Chairman TESTER. I have got you. It is fair to say that you are not alone in this, and that is why the reimbursement is so tough.

Ms. WILTON. Correct.

Chairman TESTER. I mean, look, the work that your people do, dealing with—all across the board here, it is hard work.

Ms. WILTON. Yes.

Chairman TESTER. I mean, it is hard work, and not everybody is wired for it.

Ms. WILTON. No.

Chairman TESTER. And so what you pay makes a difference whether people are going to do that or go flip hamburgers at McDonald's.

Ms. WILTON. Right.

Chairman TESTER. I want to talk about the Dole Act. You talked about it a little bit, Carl. One of the big disappointments I have had this session is a bill that came out of Committee, which was a package of five bills that passed this Committee unanimously, all bipartisan, were held up on the floor I believe because of potential—of perceived political gamesmanship. I want you to speak as to the impacts on your members as they wait for the Elizabeth Dole Act to become law because Washington, DC is playing politics.

Mr. BLAKE. Well, first, I would say I do not think your perception is wrong. I would say that is many of our perceptions about why it did not happen as well. Could be wrong. That is our perception.

Chairman TESTER. Yes.

Mr. BLAKE. I could go on about the 65 percent cap, which is not actually in the bill that went to the Senate floor. I understand, and I know that was sort of a negotiating point.

Chairman TESTER. Sure.

Mr. BLAKE. But there are other important items in there because the Veteran-Directed Care program is one of the many high priorities for us. Homemaker/Home Health.

Senator Moran talked about informing veterans just because it is mandated in the bill, which is kind of crazy to think that the bill would require notifying veterans about these things, but I use my national president as a perfect example, Charles Brown. He is served by the West Palm Beach VA, and he struggles to find home services, and he wants to be at home.

Chairman TESTER. Yep.

Mr. BLAKE. And so as a consequence, he has clamored for the Veteran-Directed Care program for a while. So imagine our surprise when our staff discovered that the Veteran-Directed Care program is actually provided out of the West Palm Beach VA Medical Center and he did not know it because the VA had never told him that. That is a problem. And I am sure that story is the same across the country.

There are too many of our members, virtually all of them currently, who rely on these services every single day, and I think that the Dole Act will open up the availability and just make people aware of what those options are and maybe put some pressure on VA to actually start moving forward.

I appreciated that the VA said that they believe they are on track to meet the President's directive regarding VDC by the end of FY '24. We will be watching closely because that matters to our members.

Chairman TESTER. Darn right. Okay. Thanks, Carl.

I want to talk about the CHARGE Act. Ms. Bell, you referenced it in your opening statement, and I know that not unlike any other nursing homes, State Veterans Homes have faced staffing challenges. That is exactly why the good Senator from Alaska, Senator Murkowski, and I teamed up to introduce the CHARGE Act to extend critical authorities related to veteran homelessness, caregivers, and State Veterans Homes.

Our bill includes an extension that you also talked about, the bed-hold waiver, too. State homes are not financially penalized if you have a staffing shortage.

And why I keep saying "staff" and why I brought it up in the previous panel is I can speak from a Montana perspective, and I will tell you what; we just need more folks, more staff, across the board. And if we do not do that, if we do not get that staff—and workforce takes a while to develop—it just puts folks in a bad situation.

So, Ms. Bell, can you speak to the importance of the CHARGE Act in assisting State Veterans Homes who are caring for our veterans?

Ms. BELL. Yes. One of the new developments in the bed-hold waiver not being active is one of my colleagues is here from Long Island State Veterans Home, and he had to reduce his bed count by 10 on Friday, and it is going to cost him about \$70,000 a month because of this bed-hold waiver not being in place.

It costs us when we are already struggling with staff as these are facilities across the country that have already closed wings or units—

Chairman TESTER. Yes.

Ms. BELL [continuing]. Because you do not have the staff to take care of the veterans and you cannot admit because you do not have the staff to take care of them. All this takes time.

So it is going to impact—he is the first, and there may be more, and we do not want that; we really do not. We want to be able to care for veterans and care for more and be able to admit.

Chairman TESTER. Yes. Well, I appreciate you guys coming on in. We see Carl Blake regularly, and we appreciate your input all the time. Ms. Bell, it is good to have you here. North Carolina is a pretty good jog, but it ain't nothing compared to what Carla Wilton had to make coming from Montana. Okay? So we appreciate you all being here.

And I also want to say thank you to the Veterans staff who stayed here. Thank you, fellows. I appreciate it. It means a lot, and I think it is smart, so just thanks.

I want to thank both panels, the witnesses from both panels.

You know, we talk about a promise we make to our servicemen and women when they sign up to serve, and that includes high quality care when they need it when they come back home. It is obvious that we have more work to do to be able to meet that obligation, and I look forward to partnering with anybody who will partner with me and folks on this Committee to make sure that we meet that obligation.

So with that, we will keep the record open for two weeks. Once again, thanks to the folks who testified, and we are adjourned.

[Whereupon, at 4:48 p.m., the hearing was adjourned.]

A P P E N D I X

Opening Statement

Opening Statement of Chairman Jon Tester
Senate Veterans' Affairs Committee
"An Abiding Commitment to Those Who Served: Examining Veterans' Access to Long Term Care"
June 7, 2023

- Thank you for joining us today to discuss veterans' access to long-term care.
- As our veteran population ages, it is critical that our nation does everything it can to meet the evolving needs and increasing demand for veterans' care.
- Today we have leaders from both VA and the Centers for Medicare and Medicaid Services (or CMS) to discuss veterans' long-term care.
- VA is integral in providing nursing home care to veterans through its Community Living Centers.
- However, VA also pays for veterans to receive nursing home care at State Veterans Homes and in nursing homes in the community.
- CMS plays a critical role in nursing home oversight for community facilities, as well as many State Veterans Homes.
- We also have the National Association of State Veterans Homes represented on our second panel to discuss how state-owned and operated facilities work with VA and CMS to deliver veterans the best care possible.
- We have three State Homes in Montana – including the Butte facility I most recently fought to open. And I know other states across the country are vying to build more.
- I'd also like to especially welcome Ms. Carla Wilton, a Montanan who is here with us today for our second panel.
- I believe she has two daughters here with us in the audience.
- Carla is the Chief Operating Officer of Immanuel Lutheran Communities - a long-term care facility in Kalispell - and I know she'll provide valuable insight from her experience serving veterans at her facility.
- It is important that nursing homes like hers get the support they need from VA, CMS, and the State so they can keep their doors open and provide top-notch care to our vets.
- In addition to nursing home care, many veterans want to age and receive care in their own homes.
- That's why it's critical the Senate stop delaying action on the Elizabeth Dole Veterans Programs Improvement Act, a package of five bills that passed unanimously out of this Committee.

- A key provision in that legislation would bolster veterans' access to vital home and community-based services.
- VSOs continue to demand action on this bill, including the Paralyzed Veterans of America – who will be rounding out our second panel.
- It's hard to think of anyone who has been as vocal as PVA in advocating for the needs of those who have served and suffered spinal cord injuries or disabilities.
- Thank you to all our witnesses for being here today.

Prepared Statements

**STATEMENT OF
M. CHRISTOPHER SASLO, DNS, APRN-BC, FAANP,
ASSISTANT UNDER SECRETARY FOR PATIENT CARE SERVICES/CHIEF
NURSING OFFICER
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS**

June 7, 2023

Good afternoon, Chairman Tester, Ranking Member Moran, and other distinguished Members of the Committee. I appreciate the opportunity to discuss Veterans' access to long-term care in both institutional and non-institutional settings. I am accompanied today by Scotte R. Hartronft, MD, MBA, FACP, FACHE, CPE Executive Director, Office of Geriatrics & Extended Care.

The older population in America is growing. For the first time in U.S. history, adults over the age of 65 are on pace to outnumber children under 18 by 2034. With this shift in demographics comes a greater demand for health services and a need to innovate care delivery to meet those demands. As Veterans age, approximately 80% will develop the need for long-term services and supports. Most of this support in the past has been provided by family members. Veterans over the age of 65 represent a greater proportion of the VA patient population than observed in other health care systems. Supporting Veterans as they age is a priority for VA. VA programs provide care and support for Veterans through a spectrum of Home- and Community-Based Services (HCBS) to inpatient and long-term care.

Home- and Community-Based Care

Ninety percent of Americans prefer to age in place, in their homes or in the least restrictive setting possible, as long as it is safe to do so¹. VA supports Veterans' expressed desire to remain in their own homes for as long as possible. VA provides and purchases an array of HCBS from qualified providers through the Community Care Network contracts and Veterans Care Agreements. In fiscal year (FY) 2022, VA served approximately 411,900 unique Veterans and spent \$3.9 billion on Home and Community-Based Care. Personal care service programs assist Veterans with self-care and activities of daily living. VHA programs include the following:

- **Adult Day Health Care:** This is a program Veterans can go to during the day for health maintenance, peer support, and therapeutic recreation. The program is designed for Veterans who need skilled services, case management, and help with activities of daily living. Most adult day health care is purchased from

¹ Aging in Place (2020). "Aging In Place Vs. Assisted Living." Retrieved from: <https://www.aginginplace.org/aging-in-place-vs-assisted-living/>

community providers, but five VA medical centers (VAMC) also provide this service within their facilities.

- **Home-Based Primary Care (HBPC):** In this program, longitudinal and comprehensive Primary Care is provided to Veterans in their homes. Care is provided by an interdisciplinary team. This evidence-based program is for Veterans with serious medical, social, and behavioral conditions for whom routine clinic-based care is not effective. HBPC national expansion efforts initiated in FY2022 thru FY2025 will support 75 new additional HBPC teams serving at least 5,625 additional Veterans.
- **Homemaker/Home Health Aide:** The program allows a trained person to come to a Veterans home and provide personal care services, such as bathing and dressing. These aides are not nurses, but they are supervised by a registered nurse who will help assess the Veteran's daily living needs.
- **Medical Foster Home (MFH):** Nursing home-level care is provided to Veterans in private homes with no more than three Veterans residing in the home. These homes provide an alternative to long-term care for those Veterans who elect to receive their long-term care in a community setting. VA inspects and approves all MFHs and ensures caregivers are well trained to provide VA planned care. There are currently 136 VA sites that offer MFH in 44 States and territories, and VA plans to expand to all VAMCs by the end of 2025. The small care environment, support and education provided by the MFH and HBPC teams enable Veterans to remain safely in the community instead of institutions.
- **Palliative and Hospice Care:** This program seeks to optimize quality of life and relief of distressing symptoms for Veterans with serious illness. Palliative care can be combined with disease-directed treatments and delivered at any time in the trajectory of an illness based on Veteran and family needs. VA has established interdisciplinary palliative care teams in every VAMC and offers to purchase or provide hospice care for all enrolled Veterans deemed appropriate for this care. Hospice services are provided by VA and also purchased for Veterans.
- **Respite Care:** This service pays for a person to come to a Veteran's home or for a Veteran to go to a program outside of their home to receive care while their family caregiver takes a break. Thus, the family caregiver is allowed time without the worry of leaving the Veteran alone and while ensuring the Veteran is able to receive necessary care.
- **Skilled Home Health Care:** Skilled home health care entails short-term health care services that can be provided to Veterans if they are homebound or live far away from a VAMC. The care is purchased and delivered by a community-based home health agency that has a contract or other agreement with VA.
- **Veteran-Directed Care:** This program gives Veterans of all ages the opportunity to receive HCBS they need in a consumer-directed way. Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver. As part of this program, Veterans and their caregivers have more access, choice, and control over their long-term care services. Currently, the Veteran Directed Care program operates at 71 VA

medical centers. VA will expand the program to all VA medical centers over the next 2 years.

Facility-Based Care

VA obligations for nursing home care in FY 2022 reached \$7.3 billion. It is projected that between FY 2019 and FY 2039, the total number of Veteran enrollees will decrease by 8% but, during this same period, the number of enrollees aged 85 and older will increase by 38%. The number of Veterans in this older age group with the highest levels of service-connected disabilities are projected to increase by over 535% over the same period. If nursing home utilization continues at the current rate among Veteran enrollees, without consideration of inflation, the total costs for all long-term services and supports are estimated to rise to more than \$15 billion per year within the next decade.

Evidence demonstrates that appropriate use of the programs and services available through VA, especially those services that are provided in HCBS, can reduce the risk of preventable hospitalizations and delay or prevent nursing home admissions and associated costs. While VA has increased access to HCBS over the last decade, there is an urgent need to accelerate the increase in the availability of these services. This is mainly because most Veterans prefer to receive care at home, and VA can improve quality care at a lower cost by providing care in these settings. In the immediate term, VA will focus actions on the following strategic initiatives: (1) expand VA-provided and community purchased HCBS for aging in place, which includes the MFH, VDC, and HBPC expansions; (2) create, test, support and disseminate evidence-based best practices in geriatric care throughout the enterprise, which includes becoming the largest Age Friendly Health System based on the Institute for Healthcare Improvement standards; (3) expand access to geriatric, palliative, home and long-term care with the use and expansion of telehealth services across all care settings and locations; (4) ensure access to modern facility-based long term care for those who require it; (5) train, recruit and retain a workforce of geriatric and palliative care staff across all disciplines; and (6) provide geriatric and palliative care training to primary care and specialty care providers of all disciplines.

When options for living at home are no longer feasible for a Veteran's care, VA can offer the Veteran care in a nursing home setting in which skilled nursing care, along with other supportive medical care services, is available 24 hours a day. VA operates 134 Community Living Centers (CLC) across the country. All Veterans receiving nursing home care through VA, whether provided in a VA-operated CLC or purchased by contract in a Community Nursing Home (CNH), must have a clinical need for that level of care. Mandatory eligibility under 38 U.S.C. § 1710A for nursing home care is provided for those Veterans with service-connected disabilities rated at 70% or higher or who need nursing home care for service-connected conditions. Veterans with mandatory nursing home eligibility can receive care in a VA CLC or a community nursing home under VA contract, and the Veterans' preferences based upon clinical indication and/or family/Veteran choice are always a consideration. Most Veterans do not meet the

mandatory service connection eligibility for nursing home care at VA expense, and they may receive care under 38 U.S.C. § 1710 based on available resources.

Veterans can also choose to receive nursing home care at a State Veterans Home (SVH). VA maintains a relationship with SVHs. VA provides quality oversight of SVHs and provides per diem payments for Veterans' care through the SVH Grant and Per Diem Program. Through this effort, States provide care to eligible Veterans across a wide range of clinical care needs through nursing home care, domiciliary care, and adult day health care programs. VA's SVH construction grant program provides funding for construction and renovation of the State home, per diem payments to assist with the daily cost of furnishing the care, and ongoing quality monitoring to ensure Veterans in SVHs receive high quality care in accordance with VA standards. Currently, there are 163 SVHs across all 50 States and Puerto Rico.

Improving High-Quality Care

VA has already embarked on an accelerated roll-out of the Veterans Directed Care (VDC) program. Under the plan, all VAMCs will have operating programs over the next 2 years. VA is also adding 75 new HBPC teams, this expansion will be focused on the VAMCs with the highest unmet need. By end of FY 2026, all VAMCs will be required to have an MFH Program. Also, VA is testing a new model of homemaker/home health aide services where the services are being provided by VA staff and not a community agency.

Additionally, the Redefining Elder Care in America Project (RECAP) pilot, currently located at three VAMCs, uses predictive analytics to identify Veterans at highest risk for nursing home admission in the next 2 years and proactively align the Veteran with needed home- and community-based services to delay or prevent nursing home placement. The Nursing Home to Home pilot focuses efforts on low-need Veterans residing in VA paid community nursing homes who wish to return to their home setting. Nursing Home to Home staff work with the individual Veteran to identify if a safe transition to home can be accomplished, and if so, coordinate the necessary care to ensure a successful return to home.

Implementation of Joseph Maxwell Cleland and Robert Joseph Memorial Veterans Benefits and Health Care Improvement Act of 2022

As required by section 161 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (the Cleland-Dole Act), the Office of Geriatrics and Extended Care (GEC) is working to (1) identify current and future needs of Veterans for long-term care based on demographic data and availability of services; (2) identify current and future needs for both institutional and non-institutional long-term care, and (3) address new and different care delivery models. GEC is engaging with the Office of Policy and Planning and Forecasting and Enrollment to gather data from the Enrollee Healthcare Projection Model on the future needs of Veterans for long-term care. Initial planning is underway.

A staffing analysis is being conducted with an emphasis on long-term support and services to have a better understanding of workforce requirements. GEC initiated a preliminary review of long-term support and services not currently available through VA, focusing on services provided by States with high-performing home- and community-based service programs. GEC anticipates no barriers in producing the report in the required one-year timeline.

In accordance with section 163 of the Cleland-Dole Act, VA is developing an implementation plan for the Geriatric Psychiatry Pilot Program at SVHs with an anticipated implementation date for the two-year pilot of 12/2023. This pilot program will recognize both the importance of interprofessional geriatric mental health services to meet the mental health needs of the SVH Veteran population and the reality of severe geriatric psychiatry (and other geriatric mental health) workforce shortages. VHA's current plan is to offer interprofessional geriatric mental health, including geriatric psychiatry, telehealth services to Veterans and teleconsultation to SVH teams in select SVHs via one or more Veterans Integrated Service Network Clinical Resource Hubs.

Implementation of section 165 of the Cleland-Dole Act is underway through collaboration between GEC and the Office of Integrated Veteran Care to establish provider and payment processes that will be used to pay caregivers in MFHs. The team is reviewing current processes and working to develop a unique process for MFHs that matches the requirements of the authorization. Due to the complexities of the various processes for contracting, ordering, and paying for this new and unique service, GEC and IVC are working to formalize a final projected date of Veteran enrollment.

Conclusion

VA's various long-term care programs provide a continuum of services for older Veterans designed to meet their needs as they change over time. Together, they have significantly improved the care and well-being of Veterans, even during times of crisis. These gains would not have been possible without consistent Congressional commitment in the form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for our Nation's Veterans and their families.

Chairman Tester, this concludes my testimony. My colleagues and I are prepared to answer any questions you may have.



Department of Veterans Affairs
Senior Executive Biography

M. Christopher Saslo, DNS, ARNP-BC-FAANP

**Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer
Veterans Health Administration**



Dr. M. Christopher Saslo assumed the role of Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (AUHS-PCS/CNO) on October 9, 2022. In this role he serves in as principal executive for oversight of Nursing, Social Work, Caregiver Support, Connected Care, Pharmacy, Sterile Processing, Geriatrics and Extended Care, Population Health, Patient Centered Care and Cultural Transformation, Physician Assistants, and Rehabilitation and Prosthetics.

Dr. Saslo served as the Acting AUSH-PCS/CNO, July 2022 thru October 2022 and prior to that as the Acting Senior Advisor to the AUSH-PCS/CNO from January 2022 thru June 2022. He has served as Associate Director for Patient Care Services at Gulf Coast Veterans Health Care System since 2014. Dr. Saslo has served as Interim Director from June 2017 to January 2018 and as acting Deputy Assistant Deputy Under Secretary for Health: Clinical Operations from October 2018 thru May 2019. In his role as ADPCS, Dr. Saslo has oversight for Inpatient and Outpatient Nursing service as well as the Office of Social Work, Sterile Processing, Clinical Informatics, Food & Nutrition and Chaplain Services. Dr. Saslo has been a Nurse for more than 37 years and has served VHA for more than 27 years. Chris has worked in areas including Ambulatory Care as both Nurse Practitioner and Program Manager, Medicine Service in the HIV and Hepatology clinics and Associate Chief Nurse for Clinical Practice in Nursing. Dr. Saslo has served as the Past President for the Florida Nurse Practitioner Network and the local NP Council of Palm Beach County.

Dr. Saslo holds a Bachelor's Degree from Marywood University in Scranton, PA, his Masters from LaSalle University in Philadelphia, PA, and a Doctorate in Nursing from Florida Atlantic University. He has been actively involved at local and national levels including the past Chair of the National Ethics Advisory for HIV/Hep C Clinical Case Registry.

CAREER CHRONOLOGY:

- 10/2022 – Present AUSH-PCS/CNO (SES-EQV), VHA
- 07/2014 – 10/2022 Associate Director for Patient Care Services Gulf Coast VHCS
 - 08/2022 – 10/2022 Acting AUSH-PCS/CNO (SES-EQV), VHA
 - 01/2022 – 07/2022 Acting Senior Advisor to the AUSH-PCS/CNO (SES-EQV), VHA
 - 10/2018 – 05/2019 Acting Deputy Assistant Deputy Under Secretary for Health for Clinical Operations(10NC) (SES-level)
- 06/2017 – 01/2018 Interim Medical Center, Gulf Coast VHCS
- 05/2009 - 07/2014 Chief Nurse for Clinical Practice West Palm Beach VAMC

EDUCATION:

- 2007 Doctor of Nursing Science, Florida Atlantic University, Boca Raton, FL
- 1995 Master of Science in Nursing (MSN), LaSalle University, Philadelphia, PA
- 1990 Bachelor of Science in Nursing (BSN), Marywood University, Scranton, PA
- 1984 Licensed Practical Nurse (LPN) Graduate, LCAVT School of Practical Nursing, Scranton, PA
- 1979 Business Administration Studies, Pennsylvania State University, Dunmore, PA



Department of Veterans Affairs
Senior Executive Biography

Scott R. Hartronft, MD, MBA, FACP, FACHE, CPE

**Executive Director, VA Office of Geriatrics & Extended Care
Veteran's Healthcare Administration**



Dr. Hartronft assumed the role of Executive Director, Office of Geriatrics and Extended Care (GEC) effective August 18, 2019. As Executive Director, his responsibilities cover the care of Veterans with complex care needs of all ages. GEC programs range in health care settings to include, but not limited to, acute care, home care, extended care, purchased home, hospice and palliative care, community, and facility-based community care.

Prior to August 2019, Dr. Hartronft served in senior VA field positions at three different complexity 1a VA Medical Centers since 2006 including Chief of Staff at VA Greater Los Angeles Health Care System, Deputy Chief of Staff VA Puget Sound Health Care System, and Associate Chief of Staff at South Texas Health Care System in San Antonio.

Of note, Dr. Hartronft is a Certified Physician Executive (CPE), Fellow of the American College of Physicians (FACP), Fellow of the American College of Healthcare Executives (FACHE) and was an Associate Dean and Clinical Professor at the UCLA School of Medicine.

Dr. Hartronft received his medical degree from the University of Oklahoma College of Medicine and completed his Master of Business Administration degree at the University of Washington's Foster School of Business.

After graduating from medical school, Dr. Hartronft went onto active duty in the U.S. Army and completed both an internship and residency in Internal Medicine and completed the joint VA/DoD Geriatric Medicine fellowship program. He served on active duty in the US. Army for eight years until 2006 before coming to the VA.

He is board certified in Internal Medicine and Geriatric Medicine.

CAREER CHRONOLOGY:

08/2019 – Present	Executive Director, Office of Geriatrics & Extended Care, Washington, DC
2016 – 2019	Chief of Staff, VA Greater Los Angeles Health Care System
2011 – 2016	Deputy Chief of Staff, VA Puget Sound Health Care System
2006 – 2011	Associate Chief of Staff, South Texas Veterans Health Care System
1998 – 2006	U.S. Army

EDUCATION:

2015	Master of Business Administration (MBA), University of Washington
1998	Doctor of Medicine (MD), University of Oklahoma
1994	Bachelor of Science (BS), Southwestern Oklahoma State University

STATEMENT OF

JONATHAN BLUM

PRINCIPAL DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER
CENTERS FOR MEDICARE & MEDICAID SERVICES

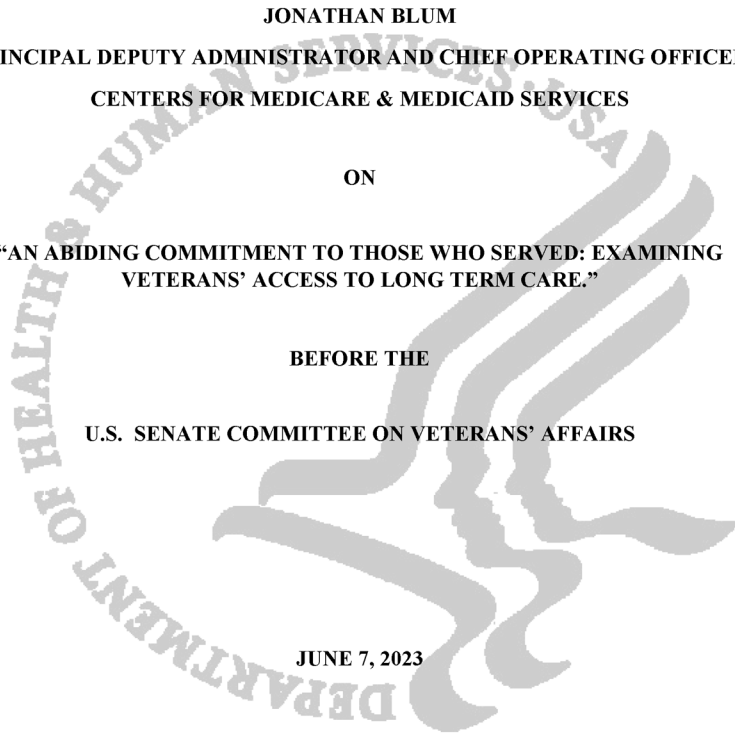
ON

“AN ABIDING COMMITMENT TO THOSE WHO SERVED: EXAMINING
VETERANS’ ACCESS TO LONG TERM CARE.”

BEFORE THE

U.S. SENATE COMMITTEE ON VETERANS’ AFFAIRS

JUNE 7, 2023



**Statement of Jonathan Blum on
“An Abiding Commitment to Those Who Served: Examining Veterans’ Access to Long
Term Care.”
U.S. Senate Committee on Veterans' Affairs
June 7, 2023**

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for the opportunity to provide an update on the Centers for Medicare & Medicaid Services’ (CMS) efforts to strengthen our nation’s nursing homes

Over the past several years, the COVID-19 Public Health Emergency (PHE) highlighted and exacerbated the long-standing challenges experienced in many nursing homes, creating an urgent need to address these issues for the well-being of all individuals, including many Veterans, residing in our nation’s federally certified nursing homes and the workers who care for them. COVID-19 outbreaks in nursing homes led to exceedingly high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population, combined with the inherent risks of congregate living in a health care setting, required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes. Ultimately, however, an unacceptable number of Americans living and working in nursing homes lost their lives over the course of the pandemic. The severity of this tragedy demands a bold response, like that underway through the Biden-Harris Administration’s initiative to improve safety and quality in the nation’s nursing homes.

Tens of billions of federal taxpayer dollars flow to nursing homes each year – and we are committed to ensuring taxpayer dollars go toward the safe, adequate, and respectful care residents deserve. Over the last few years, CMS has been intently focused on supporting nursing

homes, residents and families, and workers through the pandemic. Now that the COVID-19 PHE has ended, these lessons learned are playing an important role in informing our efforts around nursing home quality and staffing moving forward. Our policies must both increase access to care in all parts of the country and dramatically improve quality of care, especially among our lowest performing facilities.

Today, we anticipate that our nursing homes are better able to control future infection outbreaks, maintain full operations, and provide more respectful care environments as a result of the lessons learned during the COVID-19 pandemic. However, we recognize that more must be done to transform nursing homes to become even safer and higher-quality facilities for the entire country. As a result, in 2022, President Biden announced a historic initiative to improve the quality of care in nursing homes.¹ Since the announcement, CMS has focused on advancing those elements where we have full regulatory authority to implement, such as making ownership data more transparent and improving our survey and certification processes. We are working towards establishing a minimum staffing requirement in nursing home facilities to ensure that basic health and safety requirements are met. And we are working with the Congress to ensure that we have the necessary resources to fulfill our survey and certification requirements. The President's initiative recognizes that no one policy or regulation will ensure the sustained quality and access to care improvements that must be made, but we are committed to taking decisive actions to improve the quality of care these individuals receive.

¹ "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes." White House <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>

CMS's Commitment to Improving Nursing Home Quality

Nursing home oversight is one of CMS's most important tasks, and resident safety is our top priority. CMS takes seriously our responsibility to ensure that residents of long-term care facilities, and their families, are treated with the respect and dignity they deserve. It is critical to remember that for these residents, who comprise one of the most vulnerable populations in the country, nursing homes are not just a health care facility – they are their home. It is the duty of every nursing home serving Medicare and Medicaid residents to keep them safe and provide high quality care. State Veterans Homes, which provide nursing home, domiciliary, or adult day care and are owned, operated and managed by state governments, and any other long-term care facilities serving Veterans that accept Medicare and Medicaid payments, must follow all of the same Conditions of Participation as any other nursing home.

Nursing Home Survey and Certification and Enforcement

To become certified as a Medicare and Medicaid participating provider of services, a nursing home must meet federal statutory and regulatory requirements which include a list of specific requirements pertaining to health, safety, and quality.² Compliance with these requirements for participation is verified through unannounced on-site surveys. CMS works with state survey agencies (SSAs) in each of the 50 states, the District of Columbia, Puerto Rico, and other U.S. territories to perform surveys of providers and suppliers, including nursing homes. Utilizing the expertise of state officials to perform surveys means that state agencies and officials have up-to-date information on health and safety risks at facilities, and, as appropriate, can take direct action

² Sections 1819 and 1919 of the Social Security Act and 42 C.F.R. Parts 483 and 489.

against facilities through state licensure sanction. They can also recommend federal enforcement actions and remedies in response to deficiencies with health and safety requirements.

When state inspectors identify violations of federal certification requirements, the facility is required to develop a plan of correction to address identified violations within a time period depending on the scope and severity of the violation. Enforcement actions are taken against nursing homes when certain types of noncompliance are found, such as when residents are harmed, or are in immediate jeopardy of serious harm. When immediate jeopardy to resident health and safety exists (meaning that the facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death), immediate action must be taken to remove the jeopardy and correct the deficiency. Civil monetary penalties can also be assessed up to approximately \$22,000 per day (or per instance) until substantial compliance is achieved for the deficiency identified. For deficiencies that do not constitute immediate jeopardy, remedies could include directed in-service training, denial of payments, or civil monetary penalties. Termination of a facility's Medicare and Medicaid participation is required by law for nursing homes that do not achieve substantial compliance for non-immediate jeopardy deficiencies within six months. President Biden has called on Congress to raise the dollar limit on per-instance financial penalties levied on poor-performing facilities to \$1,000,000 to increase deterrence.

Strengthening the Nursing Home Special Focus Facility Program

Over the years, CMS has found that a subset of nursing homes has more problems than other nursing homes (about twice the average number of deficiencies), more serious problems than

most other nursing homes (including harm or injury experienced by residents), and a pattern of serious problems that have persisted over a long period of time. Although such nursing homes may periodically institute enough improvements to correct problems identified on one inspection, significant problems would often re-surface by the time of the next inspection. Facilities with this type of compliance history rarely address underlying systemic problems that give rise to repeated cycles of serious deficiencies, which pose risks to residents' health and safety.

To address this problem, CMS operates the Special Focus Facility (SFF) program.³ Since its inception, the SFF Program has identified the poorest-performing nursing homes in the country for increased scrutiny in order to ensure rapid and sustained improvements in the quality of care they deliver. These facilities continue to be inspected roughly twice as often as all other nursing homes – no less than once every six months – and face increasingly severe enforcement actions if improvement is not demonstrated. CMS requires that SFF nursing homes be visited in person by survey teams twice as frequently as other nursing homes (about twice per year). Facilities must pass two consecutive positive inspections to complete the SFF Program. Candidates for the SFF Program are identified based on the results from the last three standard health survey cycles and complaint survey performance converted into points based on the number of deficiencies cited and the scope and severity level of those citations. While in the SFF Program, CMS expects facilities to take meaningful actions to address the underlying and systemic issues leading to poor quality and ensure residents' safety.

³ 1819(f)(8) and 1919(f)(10) of the Social Security Act

In October 2022, CMS announced additional efforts to increase scrutiny and oversight over the country's poorest-performing nursing facilities in an effort to immediately improve the care they deliver. The changes CMS to the SFF Program is implementing are designed to incentivize facilities to quickly improve their quality and safety performance, allow the SFF Program to scrutinize more facilities over time by moving facilities through the SFF Program more quickly, and promote sustainability of facilities' improvements to ensure they do not regress post-program. Specifically, CMS strengthened the requirements for successful completion of the SFF Program; committed to terminating federal funding for facilities that don't improve within about 18-24 months; imposed more severe escalating enforcement remedies for continued noncompliance and little or no demonstrated effort to improve performance; and incentivized sustainable improvements by extending the monitoring period and maintaining readiness to impose progressively severe enforcement actions against nursing homes whose performance declines after graduation from the SFF Program. States must also consider a facility's staffing level in determining which facilities enter the SFF Program. CMS is also increasing technical assistance by increasing its engagement with these poor-performing nursing homes, through direct and immediate outreach by state and CMS officials upon their selection as an SFF, to help them understand how to improve and to access support resources like CMS Quality Improvement Organizations.

Strengthening Nursing Home Staffing to Enhance Quality of Care

Staffing in nursing homes has a substantial impact on the quality of care and outcomes residents experience, and evidence has shown that adequate staffing is closely linked to the quality of care

residents receive.⁴ This was particularly evident during the COVID-19 pandemic. In fact, a recent study of one state's nursing homes found that increasing registered nurse staffing by just 20 minutes per resident day was associated with 22 percent fewer confirmed cases of COVID-19 and 26 percent fewer COVID-19 deaths.⁵

CMS has long identified staffing as a vital component of a nursing home's ability to provide quality care, and the COVID-19 pandemic highlighted and exacerbated the long-standing staffing challenges experienced in many facilities, particularly those in rural communities. CMS has used staffing data to more accurately and effectively gauge its impact on quality of care in nursing homes. For more than 10 years, CMS has been posting information on facility staffing measures on the Medicare.gov Care Compare website. Over the last several years, CMS has made several improvements to the information reported, including transitioning to using staffing data that is electronically submitted by facilities through the Payroll-Based Journal (PBJ) system. Under the PBJ program, facility staffing information is submitted each quarter, and is auditable back to payroll and other verifiable sources.

Last year, CMS also improved accountability for staffing by posting weekend staffing and staff turnover information for each Medicare and Medicaid nursing home on the Care Compare website, and CMS now incorporates this information into the Nursing Home Five-Star Quality Rating System, which is used by CMS to rate the quality of care provided by nursing homes.

⁴ "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes." White House.

<https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>

⁵ "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates." *Journal of American Geriatrics Society*. <https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689>.

In addition, CMS plans to issue a proposed rule on minimum staffing requirements for public comment this year. CMS launched a multi-faceted approach aimed at determining the minimum level and type of staffing needed to enable safe and quality care in nursing homes. This effort included issuing a Request for Information (RFI) as part of the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System Proposed Rule⁶ and conducting a new study aimed at determining the minimum level and type of staffing needed in nursing homes. We received many comments on the RFI from members of the public identifying themselves as family members or caretakers of residents living in nursing homes. The vast majority of those comments voiced concerns related to residents not receiving adequate care due to chronic understaffing in facilities. Multiple comments stated that residents will go entire shifts without receiving toileting assistance, leading to falls or increased presence of pressure ulcers. Another commenter, whose parents live in a nursing home, noted that they visit their parents on a daily basis to ensure the provision of quality care and reported that staff in the facility have stated that they are overworked and understaffed. The information obtained through the RFI and the staffing study will help inform CMS's rulemaking efforts to update federal minimum staffing requirements in nursing homes in order to foster better outcomes for residents.

It is CMS's goal to consider all perspectives, as well as findings from the staffing study, as we develop future proposed minimum staffing requirements that advance the public's interest of

⁶ "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels" (CMS-1765-P) (87 FR 22720): <https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

safe, quality care for residents. CMS is aware of ongoing health care staffing challenges and the impact they have on rural and other underserved communities. CMS intends to issue policies that ensure safe and quality care for residents while also considering the current landscape and challenges that many providers are facing, particularly in rural and underserved areas.

CMS also issued a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin⁷ last year, which included information for states about supporting appropriate staffing in nursing homes through the Medicaid program. To ensure nursing homes are adequately resourced and staffed, CMS encouraged states to tie Medicaid payments to quality measures that will improve the safety and quality of care in nursing homes. The bulletin urged states to assess their approach to Medicaid payments to long-term care providers and utilize flexibilities provided under the law in establishing Medicaid base and supplemental payments, as appropriate, to provide adequate, performance-driven nursing facility rates to ultimately achieve better health care outcomes and address longstanding inequities for Medicaid beneficiaries residing in nursing facilities. CMS also encouraged states to continue developing long-range solutions for training and improving staffing and workforce sustainability issues in nursing homes. The bulletin indicated that CMS has approved a number of different staffing improvement incentives in state Medicaid programs and encouraged states to seek out other solutions to training and testing capacity issues in nursing facilities through collaboration with the states' Departments of Public Health that certify Nurse Aide Training and Competency Evaluation Programs to promote funded training opportunity for staff. Medicaid enrollees residing in nursing homes will only experience better

⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib08222022.pdf>

care through collaboration between states, CMS, providers, and other partners, and we look forward to working closely with them on this important effort.

Value-Based Purchasing Program and Quality Reporting and Improvement

CMS also administers two programs – the SNF Value-Based Purchasing (VBP) Program and the SNF Quality Reporting Program (QRP) – which help drive quality improvements in the care that SNFs provide to Medicare beneficiaries. The SNF VBP Program rewards SNFs with incentive payments based on the quality of care they provide. Currently, this is measured by performance on a single measure of hospital readmissions. Beginning with the FY 2026 program year, the Secretary will expand the SNF VBP Program by adding three new measures. In the FY 2023 SNF PPS final rule, CMS finalized important updates to this program, including the addition of measures that will assess SNF performance on infection prevention and management, the rate of successful discharges to the community from a SNF setting, and the total number of nursing hours per resident day. The FY 2024 SNF PPS proposed rule proposes the adoption of additional quality measures, including measures to assess the stability of the staffing within a SNF using nursing staff turnover rates, the hospitalization rate of long-stay residents, and the falls with major injury rates of long-stay residents. To prioritize the achievement of health equity and the reduction of disparities in health outcomes in SNFs, CMS is also proposing the adoption of a Health Equity Adjustment in the SNF VBP Program that rewards SNFs that perform well and whose resident population during the applicable performance period includes at least 20 percent of residents with dual eligibility status.

The SNF QRP establishes SNF quality reporting requirements and operates as a pay-for-reporting program. SNFs that do not meet reporting requirements are subject to a two-percentage-point reduction in their annual market basket percentage increase. CMS is proposing a number of improvements to the SNF QRP as part of the FY 2024 SNF PPS proposed rule, including the adoption of three new measures, removal of three measures, the modification of one measure, and changes to policies such as data completion threshold requirements. Beginning with the FY 2025 SNF QRP program year, CMS is proposing to adopt the Discharge Function Score measure, which evaluates SNF residents' functional status by calculating the percentage of Medicare Part A SNF residents who meet or exceed an expected discharge function score. Beginning with the FY 2026 SNF QRP program year, CMS is proposing to adopt the Core Q: Short Stay Discharge measure, which will calculate the percentage of residents discharged in a 6-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay based on beneficiaries' responses to a five-item questionnaire about staff, the care received, whether they would recommend the facility to friends and family, and how well their discharge needs were met. The measures and policies for the SNF QRP proposed in the FY 2024 SNF PPS proposed rule support the Administration's plan to improve safety and quality of care in nursing homes.

CMS-directed Quality Improvement Organization Covid-19 Infection Reduction Activities

CMS currently contracts with Quality Improvement Organizations (QIOs) that help providers across the health care spectrum make meaningful quality of care improvements. CMS has ensured that improving nursing home care is a core mission for QIOs. QIOs are furnishing on-demand trainings and information sharing around best practices to nursing homes. The elderly

population were and continue to be disproportionately affected by COVID-19, and were also more likely to be at risk for severe COVID-19 infection, hospitalization, and death from the disease. During the pandemic, CMS deployed the QIOs to provide individualized assistance to nursing homes serving small, rural, and the most vulnerable populations to improve nursing home quality by managing outbreaks and mitigating the spread of COVID-19.

To date, over 12,000 nursing homes received general technical assistance related to infection control challenges including the provision of educational resources and connecting with peer networks. Over 11,000 nursing homes with serious COVID-19 outbreaks received individualized technical assistance from QIOs. This assistance includes managing outbreaks, root cause analysis, making an improvement plan, and tracking and maintaining progress. Over 7,000 nursing homes received individualized hands-on QIO support for vaccine and booster uptake.

Oversight of Inappropriate Antipsychotics Use in Nursing Homes

CMS is committed to reducing the unnecessary use of antipsychotic drugs in nursing homes and holding facilities accountable for failures to comply with federal requirements. In 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes where CMS and its partners have been committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care, promote goal-directed, person-centered care for every nursing home resident, and increase the use of non-pharmacologic approaches and person-centered dementia care practices. Through this effort, significant reductions in the prevalence of inappropriate antipsychotic medication use in long-stay nursing home residents have been documented, while also maintaining access to these

medications for residents with an appropriate clinical diagnosis. Between 2011 and the fourth quarter of 2021, the national prevalence of antipsychotic medication use among long-stay nursing home residents was reduced by 39.1 percent to 14.5 percent nationwide, with every state showing reduced rates.⁸

However, inappropriate diagnosis and prescribing still occurs in too many nursing homes. In January of this year, CMS announced it is redoubling its oversight efforts to ensure that facilities are not prescribing unnecessary medications or erroneously coding nursing home residents as having schizophrenia,⁹ which can mask the facilities' true rate of antipsychotic usage.

All Medicare and Medicaid nursing homes are required to ensure that residents are free from unnecessary medications.¹⁰ On every standard survey and on relevant surveys conducted in response to complaints, surveyors review medical records to confirm that the clinical indication for any prescribed medicine, including antipsychotics and other psychotropics, is thoroughly documented. CMS has implemented specific enforcement remedies – such as denial of payment for new admissions or per-day civil money penalties – for nursing homes that have continued to have high levels of antipsychotic medication use among long-stay nursing home residents.¹¹

⁸ National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (April 2022) <https://www.cms.gov/files/document/antipsychotic-medication-use-data-report-2021q4-updated-07292022.pdf>.

⁹ “Biden-Harris Administration Takes Additional Steps to Strengthen Nursing Home Safety and Transparency” <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-additional-steps-strengthen-nursing-home-safety-and-transparency>.

¹⁰ 42 CFR 483.45(d).

¹¹ [OSO19-07-NH \(cms.gov\)](https://www.cms.gov/OSO19-07-NH)

Additionally, in January 2023, CMS began conducting targeted, off-site audits to determine whether nursing homes are accurately assessing and coding individuals with a schizophrenia diagnosis. Nursing home residents erroneously diagnosed with schizophrenia are at risk of poor care and are prescribed inappropriate antipsychotic medications. This action furthers the Administration's objective to improve the accuracy of the quality information that is publicly reported and the Nursing Home Five-Star Quality Rating System on Nursing Home Compare described below. The use of antipsychotic medications among nursing home residents is an indicator of nursing home quality and used in a nursing home's Five-Star rating calculation; however, it excludes residents with a diagnosis of schizophrenia. If an audit identifies that a facility has a pattern of inaccurately coding residents as having schizophrenia, the facility's Five-Star Quality Measure Rating on the Care Compare site will be negatively impacted. For audits that reveal inaccurate coding, CMS will downgrade the facility's Quality Measure ratings to one star, which would drop their overall star rating as well.

Increasing Access to High-Quality Nursing Homes

Medicare Payments to Skilled Nursing Facilities (SNFs)

The Medicare statute prescribes how payment is made for Medicare SNFs. Medicare Part A (Hospital Insurance) covers skilled nursing facility (SNF) care on a short-term basis for Medicare beneficiaries that have a qualifying inpatient hospital stay. In 2021, about 14,700 SNFs furnished about 1.7 million Medicare-covered stays to 1.2 million fee-for-service (FFS)

beneficiaries, or 3.4 percent of Medicare's FFS beneficiaries. In that year, Medicare FFS spending on SNF services was \$28.5 billion.¹²

SNFs are paid on the basis of a per diem prospective payment system (PPS). The SNF PPS payment rates are updated each Federal fiscal year using a SNF market basket index.

Additionally, SNF PPS payments are adjusted for case mix to reflect the relative resource intensity that would typically be associated with a given patient's clinical condition, as well as for the geographic variation in wages. In 2019, CMS implemented the new Patient Driven Payment Model (PDPM), a SNF case mix model, that focuses on clinically relevant factors, rather than volume-based service for determining Medicare payment, by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. This improved classification system puts the unique care needs of patients first while also significantly reducing administrative burden associated with the SNF PPS.

In July 2022, CMS updated Medicare payment policies for SNFs under the SNF PPS for FY 2023. CMS estimates that the aggregate impact of the payment policies would result in an increase of 2.7 percent, or approximately \$904 million, in Medicare Part A payments to SNFs in FY 2023 compared to FY 2022.¹³ CMS issued the FY 2024 SNF PPS proposed rule last month, and estimates that the aggregate impact of the payment policies included would result in a net

¹² March 2023 Report to Congress: Medicare Payment, Skilled Nursing Facilities, Medicare Payment Advisory Committee https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

¹³ Fact Sheet, Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System Final Rule, CMS <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-skilled-nursing-facility-prospective-payment-system-final-rule-cms-1765-f>.

increase of 3.7 percent, or approximately \$1.2 billion, in Medicare Part A payments to SNFs in FY 2024.¹⁴

Medicaid Payments to Nursing Homes

Nursing facility services are the second-largest category of Medicaid spending after hospital services, and Medicaid is the primary payer for long-term care, including nursing facility care and home and community-based services (HCBS), in the United States. Nursing facility services are provided by Medicaid certified nursing homes, which primarily provide three types of services: skilled nursing, rehabilitation, and long-term care. A Nursing Facility (NF) participating in Medicaid must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specific to each state, the general responsibilities of the NF are shaped by the definition of NF service in the state's Medicaid state plan, which may also specify certain types of limitations to each service. States may also devise levels of service or payment methodologies by acuity or specialization of the nursing facilities.

Under Medicaid's federal-state partnership, states have broad authority to determine Medicaid payment rates to NFs, which are generally paid on a per diem basis. According to MedPAC, combined state and federal fee-for-service Medicaid spending was \$38.4 billion in 2021.¹⁵

¹⁴ Fact Sheet, Fiscal Year 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule, CMS <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2024-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1779-p#:~:text=In%20the%20FY%202024%20SNF%20PPS%20proposed%20rule%2C%20CMS%20is,measure%20in%20the%20SNF%20QRP.>

¹⁵ March 2023 Report to Congress: Medicare Payment, Skilled Nursing Facilities, Medicare Payment Advisory Committee https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

As an alternative to long-term care provided in institutions such as nursing facilities, state Medicaid programs have the option to offer an array of long-term services and supports in beneficiaries' own homes and communities through various home and community-based services (HCBS) authorities under Medicaid. The Biden-Harris Administration, and CMS, remain committed addressing the longstanding institutional bias towards institutional settings in Medicaid and ensuring that individuals have access to quality home and community-based services and supports.

Making the Quality of Care More Transparent

Improvements to Nursing Home Care Compare

CMS created the Nursing Home Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which they may want to ask questions. The Nursing Home Care Compare website features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have quality that is far above average, and nursing homes with 1 star are considered to have quality that is far below average. There is one overall 5-star rating for each nursing home, and separate ratings for health inspections, staffing and quality measures. Consumers can find and compare Medicare- and Medicaid-certified nursing homes based on a location and can compare their staffing and the quality of care they provide.

In January 2023, CMS announced plans to take a new step to increase the transparency of nursing home information by publicly displaying survey citations that facilities are disputing.

When a facility disputes a survey deficiency, that deficiency was not posted to Care Compare until the dispute process was completed. This process usually took approximately 60 days or in some cases longer. While the number of actual deficiencies under dispute is relatively small, they can include severe instances of non-compliance such as immediate jeopardy level citations. This level of citation occurs when the health and safety of residents could be at risk for serious injury, serious harm, serious impairment or death. Displaying this information while it is under dispute can help consumers make more informed choices when it comes to evaluating a facility.¹⁶

Nursing Home Ownership Data

CMS has taken unprecedented steps regarding transparency in ownership of nursing homes, including by collecting and publicly reporting more robust corporate ownership and operating data. Making facility ownership information transparent supports efforts to identify common owners that have had histories of poor performance, to analyze data and trends on how market consolidation increases consumer costs without necessarily improving quality of care, and to evaluate the relationships between ownership and changes in health care costs and outcomes.¹⁷

In April 2022, as part of the President's efforts to increase competition and transparency, CMS publicly released, for the first time, data on mergers, acquisitions, consolidations, and changes of ownership from 2016-2022 for nursing homes enrolled in Medicare. This data, now available on data.cms.gov, is a powerful new tool for researchers, state and federal enforcement agencies, and

¹⁶ "Biden-Harris Administration Takes Additional Steps to Strengthen Nursing Home Safety and Transparency" <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-additional-steps-strengthen-nursing-home-safety-and-transparency>.

¹⁷ "For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available" <https://www.hhs.gov/about/news/2023/04/20/first-time-hhs-making-ownership-data-all-medicare-certified-hospice-home-health-agencies-publicly-available.html>.

the public to better understand the impacts of consolidation on health care prices and quality of care. In September 2022, CMS released additional data publicly on the ownership of approximately 15,000 nursing homes certified as a Medicare Skilled Nursing Facility, regardless of any change in ownership, including providing more information about organizational owners of nursing homes.¹⁸

To further increase transparency and accountability, CMS issued a proposed rule in February 2023 that would require nursing homes to disclose additional ownership and management information, including information regarding individuals or entities that provide administrative services or clinical consulting services to the nursing homes. The proposed rule would also require additional information about entities that lease or sublease property to nursing homes and defines “private equity company” and “real estate investment trust ownership” for the purposes of provider enrollment and disclosure. CMS is also taking steps to require Medicare SNFs and other providers to disclose private equity company and real estate investment trust ownership interests via a revision to the Medicare enrollment application used by these providers.

In addition to fostering competition that drives high-quality care, transparent ownership data benefits the public by assisting patients, and their loved ones, in making more informed decisions about care. Analyzing this data will support CMS efforts to develop policy approaches that can

¹⁸ “Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership” <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-continues-unprecedented-efforts-increase-transparency-nursing-home#:~:text=In%20September%202022%2C%20CMS%20released,organizational%20owners%20of%20nursing%20homes>.

improve competition in health care, a key priority for the Administration's strategy to reduce health care costs.

Nursing Home Proposals in the President's FY 2024 Budget

Survey and Certification Program Funding Increase and Program Improvements

The President's Fiscal Year (FY) 2024 budget includes multiple provisions to further strengthen nursing home oversight, transparency, and enforcement. CMS has seen an increase in the overall number of nursing home complaints since 2015, requiring additional survey resources during a time when enacted funding has generally been held constant. Specifically, compared to 2015, in recent years State Survey Agencies (SAs) conducted over 10,000 additional complaint surveys - a 19 percent increase - resulting, in part, in a 43 percent increase in the number of immediate jeopardy citations issued in that same time period.¹⁹ A strong Survey and Certification program promotes patient safety and quality and may limit more severe enforcement action over time by detecting and correcting issues earlier. In light of this, the President's FY 2024 budget requests \$566 million for Survey and Certification, an increase of \$159 million or 39 percent above the FY 2023 enacted level. This investment will strengthen the health, quality, and safety oversight for approximately 67,000 participating Medicare or Medicaid provider and supplier facilities and is needed to support the CMS actions outlined in the 2022 White House fact sheet aimed at improving safety and quality of care in the nation's nursing homes.

The President's Budget also proposes a number of policy improvements to the Survey and Certification Program. CMS requires long-term care facilities to be recertified annually for

¹⁹ Department of Health and Human Services, Fiscal Year 2024 Budget in Brief
<https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>.

participation in the Medicare program regardless of the overall quality of the facility. By contrast, CMS currently uses a risk-based approach for other facility types based on risk of poor care. The Budget proposes implementing a risk-based approach for long-term care facilities, which would allow CMS to survey high-performing facilities less frequently and redirect resources to strengthen oversight, including increasing facility inspections and quality improvement for low-performing facilities, where they are most needed. The President's Budget also proposes permitting the Secretary to charge long-term care facilities "resurvey fees" after a third visit is required to validate the correction of deficiencies that were identified during prior survey visits. Current law prohibits CMS from imposing fees on providers or suppliers for the purpose of conducting these surveys. In addition, the Budget proposes to increase the level of civil money penalties against long-term care facilities for failure to comply with federal participation requirements in Medicare and creates a penalty scale based on the severity of the deficiencies within a facility.

Hold Facility Owners Accountable for Noncompliant Closures and Substandard Care

When a long-term care facility closes, it is typically the owner of the facility that has control of its finances (including profits) and authority over the closure, and not the facility administrator. Yet under the current statute, it is the administrator that is at risk of being imposed a civil money penalty, and the owner has no accountability if they close the facility in a noncompliant manner. This proposal in the President's Budget would change the individual subject to a civil money penalty from "administrator" to "owner, operator, or owners or operators" of a facility and would add a provision that grants the Secretary authority to impose enforcement on the owners of a facility after the facility has closed. The FY2024 budget proposal would allow for enforcement

actions to be imposed against owners or operators of multiple facilities that provide persistent substandard and noncompliant care in their facilities. Further, CMS would be able to prohibit an individual or entity from obtaining a Medicare or Medicaid provider agreement for a nursing home based on the Medicare compliance history of their other owned or operated facilities. These changes will help solve a whack-a-mole problem and create accountability for owners with a track record of poor-performing homes.

Nursing Home Care Compare Website Data Validation

The FY 2024 Budget would require CMS to validate data submitted by nursing homes for the Nursing Home Care Compare website. Care Compare allows consumers to find and compare Medicare- and Medicaid-certified nursing homes based on a location and compare their staffing and the quality of care they give. Under this proposal, CMS would be able to take enforcement action against facilities that submit data that is found to be inaccurate by the new validation process, which could include a two percent reduction in claims payments, similar to the existing payment reduction for facilities that do not submit complete SNF quality reporting data.²⁰

Conclusion

The Administration is committed to continuing to improve the safety and quality of care at the nation's nursing homes. The time is now for a bold approach and a strengthened commitment to deliver on our moral responsibility to care for our nation's elders and people with disabilities, including our Veterans. Our continued action on nursing homes will be carefully coordinated alongside CMS's efforts to ensure that people can access long-term care in an appropriate setting

²⁰ Department of Health and Human Services, Fiscal Year 2024 Budget in Brief
<https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>.

of their choice, including through home and community-based services. We look forward to working with Congress, industry experts, nursing home workers, resident advocates, and – most importantly – nursing home residents and their family members, to make these much-needed improvements.

**STATEMENT OF CARL BLAKE
EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
FOR THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
ON
"AN ABIDING COMMITMENT TO THOSE WHO SERVED: EXAMINING VETERANS'
ACCESS TO LONG TERM CARE."
JUNE 7, 2023**

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the nation's obligation to ensure veterans have access to long-term care. No group of veterans better understands the importance of having access to long-term services and supports than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D).

Throughout their lives, many veterans with SCI/D require some level of assistance in taking care of their daily needs. Many disabled veterans with the greatest support needs prefer to live at home with their families and in their communities instead of an institutional setting. For decades, PVA has strongly advocated for veterans to receive care in their homes and for their caregivers to receive supports that allow them to continue supporting their veteran.

Once their physical care needs increase and their caregivers' physical abilities decrease, more of these veterans will seek help from a facility-based long-term care system that currently has zero capacity to meet their needs. Over 50 percent of the veterans on VA's SCI/D registry are over the age of 65 and most of their caregivers are aging as well. Nationwide, there are very few long-term care facilities that are capable of appropriately serving veterans with SCI/D. The Department of Veterans Affairs' (VA) number of long-term care beds for veterans with SCI/D is woefully inadequate for a rapidly aging veteran population whose care needs are not readily met in the community. VA operates just six SCI/D long-term care facilities; only one of which lies west of the Mississippi River.

Increasing Access to VA Facility-Based Long-Term Care

According to the Veterans Health Administration (VHA) directive titled, "Spinal Cord Injuries and Disorders System of Care" (VHA Directive 1176), the VA is required to operate at least 181 of its 198 authorized long-term care beds at SCI/D centers. As of last week, only 168 beds were either available for or in use. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about 3.4 beds available per state.

Many aging veterans with SCI/D need VA long-term care services but because of the Department's extremely limited capacity, they occupy acute care SCI/D center beds; are forced to reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D; or remain in precarious situations in their homes. Too often, not receiving appropriate long-term care results in veterans developing severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center. Thus, community-based long-term care is often not the best option for these veterans.

VA must adequately assess the number of veterans who need facility-based long-term care and receive funding to provide a safe margin of specialty VA long-term care capacity for veterans with SCI/D. They should also develop and implement a comprehensive plan that addresses future SCI/D veteran needs with particular emphasis on the two biggest barriers to long-term care—insufficient staffing and infrastructure.

Barriers to Accessing VA Facility-Based Long-Term Care

Staffing— Staffing shortfalls have a direct, adverse impact on the SCI/D system. Caring for veterans with SCI/D requires sharp assessment, time- and labor-intensive physical skills, and genuine empathy. Nurses who work in SCI/D centers must possess unique attributes and specialized education. All Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, and Nurse Practitioners working with the SCI/D population are required to have increased education and knowledge focused on health promotion and prevention of complications related to SCI/D. This includes the prevention and treatment of pressure injuries, aspiration pneumonia, urinary tract infections, bowel impactions, sepsis, and limb contractures.

Depending on the function level of an acute SCI/D patient, a nurse may spend an hour or more each time they enter a veteran's room doing physical transfers, repositioning, wound care, feeding assistance, bowel and bladder care, and other tasks. Nurses in other areas of work may be in and out of a patient's room in a matter of minutes. Despite the increased level of care that veterans with SCI/D require, not all SCI/D nursing staff (including licensed practical nurses and nursing assistants) receive specialty pay, which often elevates turnover rates.

Currently, VA's six SCI/D long-term care facilities are short 55 nurses. Workforce provisions in the RAISE Act (P.L. 117-103) and PACT Act (P.L. 117-168) gave VA more flexibility to fill critical positions like these, but the impact of these new authorities has yet to be realized. Still, more needs to be done. Passage of S. 10, the VA CAREERS Act, would give VA the additional tools needed to allow the department to better compete for the highly qualified medical personnel it needs to care for disabled veterans with the greatest support needs.

Offering competitive pay isn't the only problem. If VA is not able to quickly hire high quality employees, it will lack the staff needed to accomplish its mission. Right now, VA's hiring process often moves too slowly prompting many qualified individuals to accept employment in the private sector. The lengthy time needed for credential checks, introductory paperwork, and other pre-work requirements needs to be scrutinized and streamlined where possible.

Infrastructure—VA's SCI/D system of care is currently comprised of 25 acute care centers and six long-term care centers ranging in age from three to 70 years with an average age of 38. Many of the older centers have only had cosmetic or basic renovations. Thirteen of the 25 acute care and one of the six long-term care SCI/D centers continue to use four-bed patient rooms, accounting for 61 percent of the available in-patient beds. These four-bed patient rooms do not meet VA requirements and are no longer safe due to infection control issues, which often limits available bed capacity whenever patients need to be isolated. Because of the glaring absence of SCI/D long-term care beds throughout the VA system, it is not uncommon for SCI/D veterans who are eligible for long-term care benefits to receive their care while occupying an acute care bed.

As previously stated, only one of VA's six specialized long-term care facilities lies west of the Mississippi River. The facility is located in Long Beach, California, and has just 12 long-term care beds for the thousands of SCI/D veterans that reside in this area of the country. A project for a replacement acute and long-term care center was priority #2 on the Strategic Capital Investment Planning (SCIP) list in fiscal year (FY) 2023. In the Department's FY 2023 budget request, VA provided Congress with notice of its intent to obligate over \$500,000 in Advance Planning and Design Funds to verify the business case (project book) for the project. Solicitation for the project book is slated for the fall, but this is the first phase of a long design process and once the design is completed the project will then need to request funding for construction. Meanwhile, construction of a new SCI/D acute and long-term center at San Diego, California, is currently underway and scheduled to be completed in June 2024. If all goes well, it would add another 20 long-term care beds to VA's inventory, increasing the number of beds west of the Mississippi River to 32.

Another new 30-bed long-term care center at VA North Texas Health Care System in Dallas, Texas, is currently in the bid solicitation phase with construction scheduled to start later this fall. Construction was originally projected to begin this April, but these projects are not immune to the design and construction delays inherent in the VA project funding and delivery system. If everything stays on track, the project could be completed sometime in 2026. However, the North Texas project also includes shell space for an additional 30 long-term care beds (60 total) and would provide all private resident bedroom/bathrooms, shared resident dining, kitchen, and living areas to support them, as well as common resident gathering areas and space to support staff on that level. The \$45 million necessary to support building out the shell space has not been allocated, as it was viewed on the FY 2023 SCIP list as a potential future above-threshold project. The need for long-term care beds is particularly severe in the south-central region as there is not a VA SCI/D long-term care center within 1,000 miles of Dallas despite a significant regional population of veterans with SCI/D. Not fully funding this project postpones the opportunity to further address the shortage of VA long-term care beds for the aging population of veterans with SCI/D.

A project to expand and renovate the existing long-term care center in Hampton, Virginia, to eliminate four-bed resident bedrooms and shared bathrooms has been delayed due to cost increases. Seven additional projects including brand new long-term care facilities in Augusta, Georgia; Milwaukee, Wisconsin; and Minneapolis, Minnesota, and the replacement of existing ones at Bronx, New York; Brockton, Massachusetts; and Hines, Illinois, have languished for some time due to medical center nonconcurrence or other various reasons. Curiously, the replacement SCI/D center projects designed for the Bronx VA and the Brockton VA intended to modernize and expand capacity were shovel-ready but abandoned by the VA in 2014 and 2012 (respectively).

In reviewing VA's infrastructure, decisionmakers must remember that VA's SCI/D system of care is unique and not replicated outside of the VA. The VA SCI/D system of care provides a coordinated, life-long continuum of services for SCI/D veterans that is often unmatched anywhere in the community. PVA strongly believes that the VA should return to the past practice of placing greater emphasis on funding facilities that support the types of services, like SCI/D care, which the Department uniquely provides. Greater investment in areas like SCI/D care would greatly strengthen VA's specialty care services and ensure their future availability.

Even with a comprehensive strategy and adequate infrastructure funding, VA's internal capacity to manage a growing portfolio of construction projects is constrained by the number and capability of its construction management staff. To manage a larger, more complex capital asset portfolio, VA must have sufficient personnel with appropriate expertise—both within VA's Central Office and onsite throughout

the VA system, including at the local medical centers. PVA strongly supports S. 42, the Build, Utilize, Invest, Learn and Deliver (BUILD) for Veterans Act of 2023, which seeks to improve staffing to manage construction of VA assets and ensure that there are concrete master plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

Improving the Availability of VA's Home and Community-Based Services

In light of the limited access to VA facility-based long-term care and the desire of many veterans with SCI/D to receive non-institutional long-term care, VA must expand access to home and community-based services (HCBS) to meet the growing demand for long-term services and supports. Facility-based long-term care services are expensive, with institutional care costs exceeding costs for HCBS. Studies have shown that expanding HCBS entails a short-term increase in spending followed by a slower rate of institutional spending and overall long-term care cost containment.¹ Reductions in cost can be achieved by transitioning and diverting veterans from nursing home care to HCBS, if they prefer it, and the care provided meets their needs.

VA spending for institutional care doubled between 2016 and 2021; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBS—indicating the cost of institutional care is rising. Despite doubling HCBS spending between 2016 and 2021, VA currently spends just over 30 percent of its long-term care budget on HCBS, which remains far less than Medicaid's HCBS national spending average for these services among the states. VA must continue its efforts to ensure veterans integrate into and are able to participate in their community, which means having access to needed HCBS.

Caps on HCBS Care

VA is currently prohibited from spending on home care more than 65 percent of what it would cost if the veteran was provided nursing home care. When VA reaches this cap, the Department can either place the veteran into a VA or community care facility or rely on the veteran's caregivers, often family, to bear the extra burden. Depending on the services available in their area, some veterans must turn to their state's Medicaid program to receive the care they need, even for service-connected disabilities.

Amyotrophic lateral sclerosis (ALS) is presumptively related to military service and is rated by VA at the 100 percent level. And yet, we are aware of many ALS veterans who are not receiving proper home care. One veteran with ALS who uses a gastrostomy tube, has a tracheostomy and is ventilator dependent was only able to get a nurse to come to his home for two-hour visits, two times per week to check his vitals. Unfortunately, these hours were not enough to care for his medical complexities and the VA was unable to provide additional services due to cost. Instead, VA told him he could receive 24/7 skilled nursing at a facility. Another ALS veteran needs 120 hours of skilled care per week in order for him to be at home with his wife and family. Medicaid authorized 70 hours per week but the VA was unable to approve the additional coverage due to the cost and instead the veteran is in a much costlier facility. And another ALS veteran lives with his wife in their home but his wife is responsible for around 130 hours of care a week on her own. She can no longer afford to pay out of pocket for additional care. The VA's only option was to place the veteran in a facility due to the cap.

¹ [Do noninstitutional long-term care services reduce Medicaid spending?](#)

It isn't just ALS veterans who are impacted by this cap. A 39-year-old SCI veteran who is tracheostomy dependent has been in a facility since 2019 due to the cost of his care. He has a 10-year-old daughter that he has not been able to see since before COVID. Another veteran with a form of multiple sclerosis who has a gastrostomy tube, a tracheostomy, and is ventilator dependent is on the verge of ending up in a facility. His family needs eight hours of care per day on the weekdays but VA is only able to approve 16 hours per week due to the cap.

Congress must eliminate the cap on HCBS and allow the VA to cover the full cost of needed services for these veterans and others like them. It is inexcusable that veterans, particularly those with catastrophic service-connected disabilities, are not able to receive the care they have earned and deserve because of an artificial cap on the care VA can provide to them. Instead, we are exhausting their caregivers and leaving them struggling to cobble together the services and supports they need to stay home with their families.

Veteran Directed Care Program Expansion

PVA strongly supports expanding the Veteran Directed Care (VDC) program to all VA medical centers. The VDC program allows veterans to receive HCBS in a consumer-directed way and is designed for veterans who need personal care services and help with their activities of daily living. Examples of the types of assistance they can receive include help with bathing, dressing, or fixing meals. VDC also offers support for veterans who are isolated, or whose caregiver is overburdened. Veterans are given a budget for services that is managed by the veteran or the veteran's representative.

Unfortunately, the VDC program is not available at many VA medical centers and it currently has an enrollment of only about 6,000 veterans. Our members and other veterans are constantly asking for help in getting this program implemented at their VA health care facility. Milton, a PVA member from Ohio, is one of many veterans waiting more than four years for the Cleveland VA to implement the program. Even if the program is available at a particular facility, veterans may not be aware of it or given the opportunity to enroll. PVA's National President Charles Brown was made aware last year by PVA staff, not VA, that the program was available at his VA medical center. After several attempts to learn about accessing the program, he was told he had not been considered for it. Veterans should be given the choice to access this program where it is available.

Last year, VA announced plans to expand the VDC program to 75 additional sites over a five-year period. We are pleased that VA's Under Secretary for Health recently directed VHA to accelerate the timeline. In April, the President signed the Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers requiring VA to consider not only expanding the program by the end of fiscal year 2024 but also to have an expansion implementation plan ready by this month. We urge Congress to provide the necessary funding so every VA medical center can offer a robust VDC program as quickly as possible. We also call on VA to prioritize medical centers with an SCI/D center as many of these veterans are prime candidates for participating in VDC.

Homemaker and Home Health Aid Care Limitations

Another major concern of our members is VA not authorizing adequate hours to care for their home care needs. As previously noted, the cost of VA purchased home health care services may not exceed 65 percent of the amount it would cost if the veteran was placed in a nursing home. Even if we use costs at

the higher end of the spectrum for nursing homes and home health aides, this formula should result in 50 hours or more of VA home care per month.

A VA physician determines and prescribes the number of home care hours needed by a veteran in accordance with VHA Handbook 1140.6 titled, "Purchased Home Health Care Service Procedures." A physician might put in a consult for 28 hours, but the request may only be authorized for 21 hours or less. Veterans often contact PVA as the hours of care they receive are not adequate, and we must initiate an appeal to secure more assistance.

In April 2018, VHA issued an educational memo entitled, "Home Health Care Changes," describing a new methodology for determining the number of home care hours veterans are to receive. The memo noted that the "changes may dramatically impact the amount of services offered to Veterans enrolled in HHC, specifically engaged with the Home Health Aid and Home Maker Services." PVA has heard concerns from VA SCI/D providers that the current methodology fails to consider the unique home care needs of veterans with SCI/D, including the amount of time and number of providers who might be needed to provide required assistance.

While we recognize VA's challenge with limited resources and that our veterans are not the only ones using VA long-term care, they must receive the hours their doctor believes are needed for their care.

Veterans also have had difficulty receiving authorized care as agencies are having trouble finding sufficient numbers of workers to provide it. People often assume that veterans home care needs are fully cared for because of the care provided through the VA. Unfortunately, that is not always the case. Three months ago, our National President shared his personal story about a day when no nurse arrived to help him get out of bed. The VA-contracted home health agency providing his care was unable to find a nurse to assist him, and after repeated calls, told him that it was his responsibility to find a backup nurse for situations like this. This was extremely disappointing for me to hear. When care providers fail to see the seriousness of our situations, it is dehumanizing, and it cannot be allowed to continue.

Congress must recognize that the veterans population is aging and that veterans like PVA members are catastrophically disabled and at the same time losing regained function due to age. Veterans who must rely on caregivers, including those who have limited or no family support, have earned the right to live in their homes in a dignified and safe manner. VA's community home care providers must be held accountable for providing the care that we have earned with our service.

Direct Care Workforce Shortages

Even when veterans have access to programs like VDC or Homemaker/Home Health, it can be challenging to find home care workers. That is the experience of Ron, a PVA member from Minnesota who sustained a traumatic SCI in a vehicle accident in the spring of 2020. After spending four months in rehabilitation, he was released to an assisted living facility that did not meet his needs; so, he briefly lived with his mother while he and his family built an accessible home. In the fall of 2020, VA authorized 24-hour care for him in his home and Ron was thrilled to have this option. His wife is very supportive but often feels sad and helpless because she is physically unable to care for him. He depends entirely on the home health staff for his daily care, health, and welfare.

Unfortunately, because VA did not have home care staff, he had to go through a community agency. Despite having many hours authorized, he has never found enough qualified people to fill them. He is fortunate when he has someone to get him out of bed and help him through the day. Oftentimes, he goes to bed at 7 p.m. because help isn't available at his usual bedtime of 9 or 10 p.m. He regularly spends weekends in bed because no staff is available to assist him and he is depressed and frustrated because he can't find the direct care workers he needs to assist him with daily activities.

The shortage of caregivers or home care workers is not unique to the VA. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. I share these stories to emphasize how precarious the HCBS/long-term care system is and how the lack of home care providers is adversely impacting the care and quality-of-life of veterans with SCI/D. Veterans with disabilities have the right to quality care in their homes. Increasing pay for essential caregivers is a necessary component of attracting and retaining a diverse set of people to provide HCBS but raising pay alone is not sufficient to solve the crisis we face. Utilizing multiple strategies such as raising public awareness about the need and value of caregiving jobs, providing prospective workers quality training, and developing caregiving as a sound career choice are a few of the other changes that could help turn this problem around.

In light of the tremendous need to improve access to HCBS, PVA strongly supports S. 141, the Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act. This critically important legislation would make urgently needed improvements to VA HCBS, including several that target our concerns about current program shortfalls.

We appreciated the Committee's markup of an amended version of this legislation and were disappointed when a recent attempt to advance this bill along with five others in an omnibus package did not succeed. We sincerely hope the differences that led to that failed effort can be resolved, so veterans can receive the long-term care they desperately need. At the same time, I ask you to continue working with your counterparts in the House, with VA, and the Congressional Budget Office to resolve concerns with lifting the cap on the amount VA can pay for home care and pass it into law this year. We greatly appreciate the commitment to resolve this issue, and PVA is ready to assist you any way we can to expedite passage. Lifting the cap on VA-provided HCBS is vital to the health, safety, and independence of veterans who have paid the highest price for their service to our nation. The cost of providing them with needed services and supports cannot be a limitation we place on their care.

Strengthening Assistance for Family Caregivers

Finally, a conversation about long-term care would not be complete without commenting on VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC). Executing this program continues to be challenging for the VA and we were pleased that the Department extended the transition period for legacy applicants and legacy participants until September 30, 2025.

We are disappointed, however, that action has yet to be taken to revise the restrictive rules that are preventing seriously injured disabled veterans who have the greatest support needs from qualifying for the program. To their credit, VA worked closely with caregivers, veterans, and stakeholders, including PVA, to identify changes that could be made under existing authorities and those that would require congressional action. Unfortunately, no changes have been made yet and each day of delay prevents hundreds of veterans and their caregivers from accessing the benefits this important program provides.

We are also concerned with the way VA decides which tier veterans are assigned to in the PCAFC. VA currently has two categories for determining stipend payments, tier one and tier two. Tier one is for veterans whom VA has determined can self-sustain in the community. Tier two is for veterans who cannot do so. The VA defines “unable to self-sustain in the community” to mean an eligible veteran that requires personal care services each time he or she completes three or more of the seven activities of daily living (ADLs), and is fully dependent on a caregiver to complete such ADLs or has a need for supervision, protection, or instruction on a continuous basis. VA defines inability to perform an ADL to mean the veteran or servicemember requires personal care services each time he or she completes one or more of the ADLs.

VA has determined that many PVA members are eligible for Special Monthly Compensation (SMC). SMC is a higher rate of compensation paid due to special circumstances, such as the need for aid and attendance by another person or a specific disability, such as loss of use of one hand or leg. SMC ratings range from K through S, with R-2 being the highest level. We are at a loss to explain how our members with the highest SMC rating receive the lower level of compensation through PCAFC if they can even get in the program at all. PVA National’s Senior Vice President Robert Thomas is one of these individuals. Mr. Thomas is a quadriplegic who suffered an injury while serving in the Army back in 1991. He also has an SMC rating of R-2—the *highest level*. However, he applied for VA’s PCAFC and was subsequently approved but assigned into tier one—the *lowest PCAFC payment tier*. We are concerned that VA has two separate programs to determine the need for assistance with ADLs that are resulting in different determinations. PCAFC plays an important role in the effective delivery of long-term care and we encourage this Committee to expand its oversight of the program and work with VA to eliminate these types of decisions.

PVA appreciates this opportunity to express our views on veteran’s access to long-term care and we look forward to working with the Committee to eliminate some of the identified barriers.



NATIONAL ASSOCIATION OF STATE VETERANS HOMES

“Caring for America’s Heroes”

**Testimony of
WHITNEY BELL, PRESIDENT
NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)**

**Before the
SENATE COMMITTEE ON VETERANS’ AFFAIRS**

**Hearing on
“AN ABIDING COMMITMENT TO THOSE WHO SERVED:
EXAMINING VETERANS’ ACCESS TO LONG TERM CARE.”**

JUNE 7, 2023

Chairman Tester, Ranking Member Moran, and Members of the Committee:

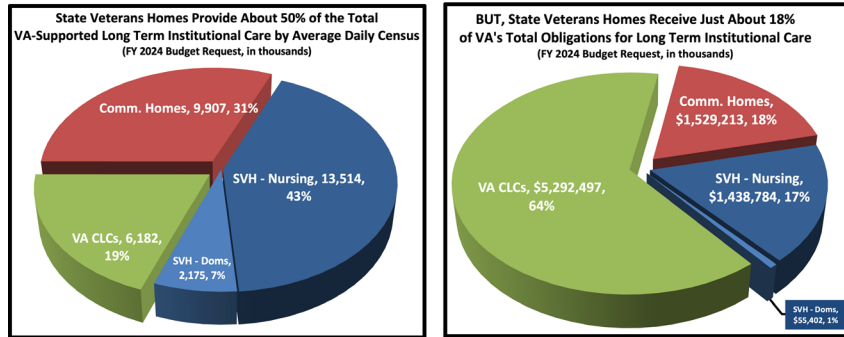
Thank you for inviting the National Association of State Veterans Homes (NASVH) to testify on ways to strengthen and expand long term care for aging and ill veterans. As you know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our Homes through education, networking, and advocacy.

My full-time job is Administrator of the State Veterans Home in Fayetteville, North Carolina, where I oversee a 150 bed facility providing skilled nursing care to aging and disabled veterans. Today I am pleased to share with the Committee my direct experiences and observations, together with those of my NASVH colleagues, about how the pandemic has and continues to challenge State Veterans Homes, and ways we can work together with VA to help bring high-quality long term care services and supports to more veterans, regardless of where they live.

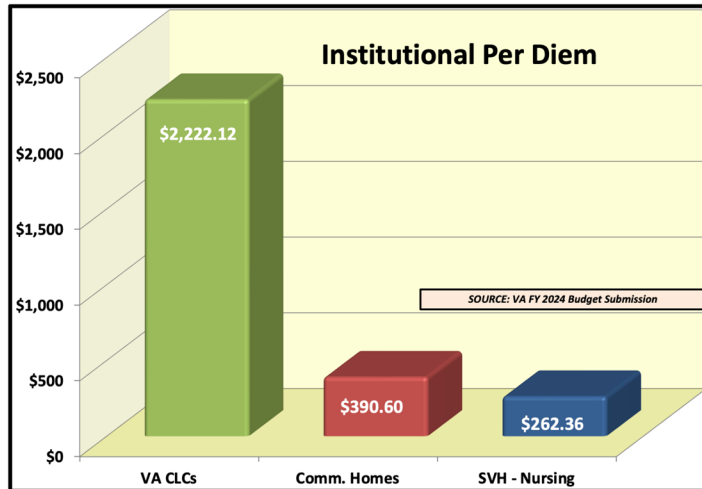
Background

The State Veterans Homes program is a partnership between the federal government and state governments that dates back to the post-Civil War period. Today, there are 163 State Veteran Homes located in all 50 states and Puerto Rico, with over 30,000 authorized beds providing a mix of skilled nursing care, domiciliary care, and adult day health care.

SVHs provide approximately half of all federally-supported institutional long-term care for our nation's veterans according to VA's FY 2024 budget submission. However, State Veterans Homes will consume less than 20% of VA's total FY 2024 obligations for veterans' long term nursing home care.



According to VA, the institutional per diem for SVH skilled nursing care is about 33% less than private sector community nursing homes and about 88% less than VA's Community Living Centers (CLCs). While there are important differences among the three programs, it's clear that the SVH partnership provides tremendous value for VA and for the veterans it serves.



To help cover the cost of America's veterans who choose to reside in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and adult day health

care (ADHC). VA also provides State Home Construction Grants to cover up to 65 percent of the cost to build, renovate and maintain SVHs, with states required to provide at least 35 percent in matching funds for those projects.

As a responsibility of providing federal funding, VA certifies and closely monitors the care and treatment of veterans in SVHs. Although VA does not have direct statutory “...*authority over the management or control of any State home.*” [38 USC 1742(b)], federal law provides VA the authority to “...*inspect any State home at such times as the Secretary deems necessary.*” and to withhold per diem payments if VA determines that the Home fails, “*to meet such standards as the Secretary shall prescribe...*” [38 USC 1742(a)]

Oversight of State Veterans Homes

VA performs a comprehensive recognition survey before any new SVH can be certified to receive federal financial support, and then conducts annual inspection surveys of each Home to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of the Home’s facilities, services, clinical care, safety protocols and financial operations.

There are extensive regulations covering every aspect of SVH operations (38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210) providing a description of the standards for skilled nursing facilities that every State Veteran Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the safe physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA’s annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NFPA) Life Safety Codes and Standards. Finally, VA conducts a comprehensive financial audit of the Home’s financial operations and ensures proper stewardship of residents’ personal funds. There are similarly detailed regulations VA uses to oversee domiciliary and adult day health care programs run by State Veterans Homes.

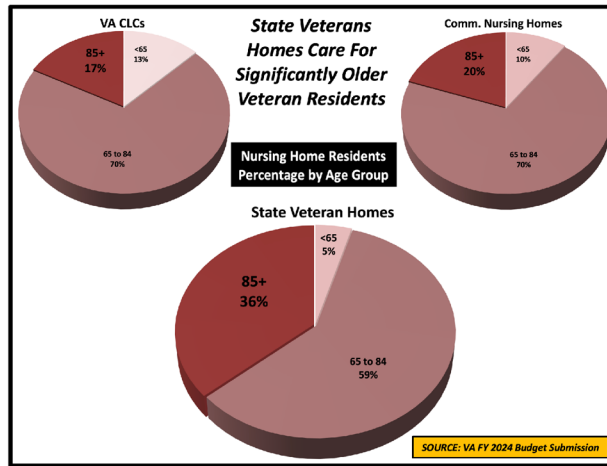
About 72 percent of State Veterans Homes are also certified to receive Medicare support for their residents and must undergo annual inspections by the Centers for Medicare and Medicaid Services (CMS) to assure safety and quality care. The CMS inspection survey includes more than 90 percent of the same clinical life and safety sections of the VA inspection survey in a week-long process. All deficiencies identified by the CMS inspection must be corrected by the Home as a condition of continuing to receive CMS financial support.

In addition to the VA and CMS inspections, State Veterans Homes may be subject to inspections and audits from VA’s Office of Inspector General as well as the Civil Rights Division of the Department of Justice. Furthermore, SVHs usually function within or are overseen by a state’s department or division of veterans’ affairs, public health, or other accountable agency, and typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public body. State Veterans Homes also receive regular and frequent inspections by state and local authorities examining fire safety preparedness, pharmaceutical

practices, health and sanitary protocols, food safety practices and other public health and sanitization protocols. As public institutions, SVHs operate with complete transparency.

Expand Both Home and Community Based Services and Traditional Nursing Home Care

There are an estimated 8.4 million living veterans aged 65 or older, including approximately 2.6 million who are 80 or older, of which about 1.3 million are 85 or older. VA data shows that SVHs care for a significantly older veteran population than either VA CLCs or community (contracted) nursing homes; about twice as high a percentage. State Homes also provide more long-stay care and more end-of-life care, as would be expected for their older veteran population.



In total, the average daily census (ADC) for VA-supported nursing home, both long and short stay, is only about 32,000 veterans; which is less than one-half of 1% of the approximately 8.4 million living veterans 65 or older, and just over 2% of those 85 plus; and these percentages are projected by VA to drop in future years.

Alarming, this represents a dramatic decrease in VA-supported nursing home care provided to veterans since the onset of the pandemic. In FY 2019, the total ADC for all VA-supported nursing home care was over 42,000 with a total of more than 115,000 veterans cared for. For FY 2024, VA projects an ADC of less than 32,000 veterans, which is a 23% reduction. The total number of veteran patients for FY 2024 is projected to drop to approximately 80,000, which would be about a 30% reduction compared to FY 2019. For State Veterans Homes, the FY 2024 ADC for nursing home care is projected to be 30% less than prior to the pandemic, dropping from over 20,000 veterans to less than 14,000, while the total number of veteran patients cared for is expected to be 33% less, down from about 30,000 in FY 2019 to about 20,000.

Over the past decade, VA has been placing greater focus and resources on home and community-based services (HCBS) with the stated goal of “rebalancing” between institutional and non-

institutional care. NASVH certainly understands and strongly supports the need for expanded HCBS options, however the amount of nursing home care offered by VA is woefully inadequate to the overall need, and while it may diminish some, it will never go away. There will always be significant numbers of veterans who lack adequate family support to allow them to age at home. There are also many of veterans who will be able to utilize HCBS for some time but will eventually reach an age and stage where traditional nursing home care is required. For these reasons, Congress and VA must continue to make smart investments to sustain and expand traditional bed-based care. NASVH strongly supports expanding home and community based care, but it should be in addition to, not as a subtraction from facility-based care.

NASVH and our member State Veterans Homes will continue to seek new and innovative ways of delivering long term services to aging and ill veterans, including supporting veterans who want to age in place; however, it would be a grave mistake to neglect or reduce the existing SVH infrastructure. SVHs understand aging veterans' needs and have expertise in connecting them with their VA benefits and services, as well as helping them with their eligibility. With our clinical expertise and existing infrastructure, State Veterans Homes could potentially serve as hubs in communities across the country, particularly in rural areas, to offer aging veterans a full spectrum of long term support services, including home-based care.

How the COVID-19 Pandemic Has Impacted State Veterans Homes

Mr. Chairman, when COVID-19 first emerged in early 2020, State Veterans Homes were among the first institutions to take significant precautions to protect our residents. Battling communicable viruses has always been a regular part of our operations and we have strong infection control regimens which have long been utilized to help prevent and mitigate the spread of influenza and other viruses in our facilities. However, the outbreak and spread of COVID-19, particularly in its early asymptomatic form, made it virtually impossible to prevent it from entering any facility or location in the country. Despite the significant precautions taken – including enhanced use of personal protective equipment (PPE), suspension of visitation and new admissions, screening of staff and residents for symptoms, and strict social distancing – the lack of vaccines, treatments and testing capacity made all nursing homes a prime target of COVID-19.

It is important to note that veterans in State Veterans Homes are primarily older men who have significant disabilities and comorbidities, and that studies have concluded that COVID-19 disproportionately affected older men with underlying health conditions. As noted above, the percentage of veterans residing in SVHs aged 85 or older is about twice as high as VA's CLCs or community nursing homes.

From the onset of the pandemic, State Veterans Homes proactively sought to procure sufficient PPE to protect veterans and staff. However, inadequate national inventory and stockpiles of PPE – particularly N95 masks, isolation gowns and face shields – posed a tremendous problem. Another critical challenge was the inability to quickly and accurately test for COVID-19 and receive timely, valid results for both residents and staff.

As a result, when one resident or staff member tested positive, Homes would often quarantine numerous other staff or residents who might have come in contact with the person who tested

positive. This resulted in large numbers of staff in some State Veterans Homes being required to remain at home until they passed a 14-day quarantine period or had one or more negative test results to indicate they did not carry the virus. Consequently, SVHs were forced to dramatically increase overtime for remaining staff or to bring in additional temporary staff from agencies, at a greatly increased cost to the Homes.

As the pandemic stretched from months to years, the impact on the finances of SVHs has been devastating. Every State Veteran Home has had to significantly increase expenditures for PPE, cleaning and sanitizing supplies, and laundry services. Depending on the level of COVID-19 spread in a facility, Homes have had enormous increases in personnel costs to cover wages, overtime, hazard pay, sick leave and temporary staffing. In addition, many Homes have made modifications to buildings and rooms for isolation and further enhanced sanitization measures to include new technologies and new equipment.

At the same time, occupancy levels in most SVHs declined as veteran residents passed away due to COVID and non-COVID causes, and because new admissions were suspended. Today, even with effective vaccines, treatments, and testing now available to mitigate many of the dangers from COVID-19, SVHs still face significant challenges in bringing their occupancy rates back up to normal levels, primarily due to national staffing shortages impacting all health care facilities. As a result, the level of VA per diem support provided each year to State Veterans Homes has declined significantly over the past three years, creating serious financial challenges for Homes to remain solvent at a time when their state budgets are also in crisis.

Waivers During the Public Health Emergency

As the pandemic quickly took hold in March 2020, NASVH worked with this Committee and its counterpart in the House to look for ways to mitigate the impact of COVID-19. One of the key challenges was meeting clinical staffing requirements as employees either contracted COVID-19 or had to be quarantined due to exposure. To help limit the loss of financial support during the pandemic, Congress included provisions in the CARES Act (P.L. 116-136) to provide temporary waivers from occupancy rates and veteran percentage requirements, as well as a provision authorizing VA to provide PPE to SVHs during this public health emergency. VA was also able to waive the bed hold payment minimum occupancy requirement during the public health emergency so that SVHs would not lose per diem for veterans who were receiving temporary in-patient treatment in an acute care setting.

However, with the formal end of the public health emergency on May 11, 2023, SVHs are now losing this significant financial support from VA, which is particularly challenging at a time when staffing shortages continue to limit our ability to provide services to more veterans who are presently in need of our services

Chairman Tester, we want to thank you and Senator Murkowski (AK) for introducing S. 1436, the *CHARGE Act*, which, among other provisions, would allow SVHs to receive per diem payments for bed-holds even when they do not meet the required 90% occupancy rate. The bill would also continue to allow VA to provide PPE and supplies to SVHs at its discretion to help keep residents and staff safe during other health emergencies. We hope that the Committee will be able to move this legislation swiftly through the Senate.

Increase Support for SVH Per Diem and Construction Grants

NASVH would also like to thank this Committee for all its outreach and support during the pandemic, particularly for helping to secure emergency supplemental funding for SVHs. As a result of provisions included in the American Rescue Plan (ARP) Act of 2021 and the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act as amended by the Consolidated Appropriations Act, 2021, VA was able to provide \$1 billion in supplemental support to SVHs at a time of dire need.

However, although the public health emergency has formally ended, State Veterans Homes continue to face significant challenges in caring for aging and disabled veterans, and we respectfully ask this Committee to continue working with us to address these needs.

Although VA is authorized to pay a basic per diem that covers up to 50% of the cost of a veteran's care, the basic per diem rates in recent years have been less than 30% of the cost of care, and even lower during the height of the pandemic. NASVH is seeking new legislation that would set the basic per diem rate permanently at 50% of the daily cost of care.

We also ask Congress to work with VA to review current regulations pertaining to the prevailing per diem payments for State Homes and enact a methodology that pays for all specialty care services (i.e., psychiatric care) and high-cost medications. The VA should further review current regulations to add services such as outpatient therapy to be covered services offered by VA and made part of the State Home per diem program.

NASVH is also seeking support from Congress to fully fund the State Home Construction Grant program. Over the past decade, annual appropriations for this program have been extremely volatile: typically providing funding for only a small portion of the qualified state matching grants, but fortunately with a couple of years that met the full demand for federal matching funds. Last week VA released its updated FY 2023 VA State Home Construction Grant Priority List which shows there are now 73 Priority Group 1 projects, those that already have the state matching funds secured, with an estimated VA share totaling more than \$1 billion. In addition, there are 32 other submitted grant requests awaiting state matching funding (Priorities 2 to 7), for which the federal share would require an additional \$720 million.

Unfortunately, VA's FY 2023 appropriation for State Home Construction Grants is only \$150 million, which will fully fund just 6 of the 73 approved but pending projects, and partially fund one large new Home construction project in California. For FY 2024, VA has requested just \$164 million, which would not even complete funding for the California project next year.

Mr. Chairman, NASVH is seeking support from this Committee and Congress to substantially increase funding for the State Home Construction Grant program – at least \$600 million in FY 2024 —so that states can renovate, upgrade, and replace aging facilities to provide greater safety and quality of care. Many of these grants will be used to modernize critical air and water systems that are vital to preventing the spread of viruses and contagious diseases.

Faithfully Implement Standardized Sharing Agreements and Geriatric-Psychiatry Pilot

Public Law 117-328 enacted last December requires VA to create a standardized process for State Veterans Homes to enter into sharing agreements with VA medical facilities providing medical services to veterans in SVHs. The lack of standardized sharing agreements has been a longstanding problem that hinders SVHs and the VA from effectively working together to ensure veterans receive all the care they have earned. The law also requires VA to create a new geriatric psychiatry pilot program at State Veterans Homes. Aging veterans with severe mental health and behavioral issues represent a challenge for both VA and SVHs due to the high level of supervision and intensive care required, particularly for veterans who pose a danger to themselves or others. Several states have already indicated a willingness to move forward with implementing geriatric psychiatry programs, including Louisiana, Washington, and West Virginia. For the pilot program to be successful, however, VA must provide Veterans Homes with adequate financial support that allows them to develop new and innovative programs.

Since enactment of this legislation, NASVH has had limited conversations with VA about how and when they would be implementing these critical statutory provisions. NASVH is asking Congress to help ensure that VA implements these provisions expeditiously, faithfully, and in full consultation with leaders from NASVH and State Veterans Homes.

New Legislation to Address Staffing Challenges

As this Committee is aware, there is a national staffing crisis affecting virtually every health care system, particularly for nurses and other critical clinical positions. We have been grateful for the Nurse Recruitment and Retention Scholarship program which has had a positive impact on a number of SVHs. We are asking Congress to expand that program so that more Homes can benefit from it. At the same time, we believe that a similar program for other critical staffing vacancies could help boost the ability of SVHs to compete with private sector employers who are able to offer higher salaries and benefit packages. We hope to work with this Committee to develop new and innovative programs that will help SVHs recruit and retain sufficient staffing to allow more veterans to be served by our Homes.

Enact Legislation to Strengthen Domiciliary Programs and Begin Assisted Living Care

In addition to skilled nursing care, there are more than 20 states offering domiciliary care in over 50 SVHs, which provide alternative long term support to about 2,000 veterans every day who would not qualify for skilled nursing care, but who do need shelter and supportive services. The level of care in SVH domiciliary programs varies from state to state, with some providing only basic food and shelter, while others offer more enhanced levels of support that may include social, vocational and employment services. Although some states have chosen to offer levels of care that are higher than domiciliary care but less intensive than skilled nursing care; however, VA is not authorized to provide financial support for veterans in those programs.

New regulations promulgated in 2019 have made it even more difficult to admit veterans into domiciliary programs, particularly veterans who have dementia but do not qualify for nursing

home care. As a result, some State Veterans Homes have lost millions of dollars of federal support for these veterans, threatening the viability of domiciliary programs, and in some instances, they have been forced to pass these costs onto veterans themselves.

To address these problems, Senators King and Collins of Maine introduced S. 1612, the *Reimburse Veterans for Domiciliary Care Act*, which would mandate that VA propose and finalize regulations to reimburse SVHs for domiciliary care covered by VA prior to the 2019 regulatory changes. NASVH supports this legislation and calls on the Committee to approve it.

In addition, with millions of aging veterans who can no longer live independently but whose needs fall in between the two levels of VA-supported institutional care in State Veterans Homes, NASVH believes it is time for VA to begin offering assisted living care. Authorizing VA to support assisted living programs in State Veterans Homes could provide a critical new option for veterans who need greater support than offered by domiciliary care and would cost less than skilled nursing care.

NASVH is pleased to offer our strongest support for S. 495, the *Expanding Veterans' Options for Long Term Care Act*, legislation that would authorize the VA to create a three-year pilot program to provide assisted living care for veterans at six sites. In particular, we appreciate that the legislation requires two of the six pilot sites to be located at State Veterans Homes. On behalf of our member State Homes and the veterans we serve, I want to thank Senators Tester and Moran for introducing this legislation, along with other Senators who have supported it, and call for its swift consideration and approval by the Committee.

Incentivize Expansion of Adult Day Health Care Programs

In addition to skilled nursing and domiciliary care programs, SVHs are authorized to offer Adult Day Health Care (ADHC), which is a non-institutional alternative to a skilled nursing facility for aging veterans who have sufficient family support to remain in their own homes, but who need or will benefit from a day program that promotes wellness, health maintenance, and socialization. ADHC can help to maximize the participant's independence and enhance their quality of life, as well as provide much-needed respite for family caregivers.

Medical Supervision Model ADHC provides a higher level of care, including comprehensive medical, nursing, and personal care services combined with social activities for physically or cognitively impaired adults. This program is staffed by caring and compassionate teams of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs. It can help veterans remain in their own homes for additional months or years, thereby improving their quality of life. It can also lower the cost and burden on VA by deferring or delaying their use of more expensive skilled nursing care and can help frail, elderly veterans avoid unnecessary emergency room admissions and hospitalizations. There are currently only three State Veterans Homes operating ADHC programs – New York, Minnesota, and Hawaii – although several other states are working on plans that could lead to additional programs in the future.

To encourage more SVHs to open ADHC programs, NASVH offers two recommendations. First, VA and Congress should allow the State Veterans Home Construction Grant program to support

the construction, modification, or expansion of SVH facilities to operate ADHC programs. Second, VA should authorize SVHs to establish satellite ADHC programs outside their facilities and campuses in more conveniently located areas where there are high concentrations of veterans who could use the services. Given the small size of these programs, the Construction Grant program could also fund grants for SVHs to reconfigure existing private medical or office space to meet the needs of ADHC programs.

Explore Additional Home-Based Care Solutions for State Veterans Homes

In addition to expanding ADHC programs, NASVH also recommends that Congress and VA explore other way for SVHs to develop new home-based programs, including ones similar to VA's Home Based Primary Care, Homemake Home Health Aide Care, Respite Care, Palliative Care and Skilled Home Health Care. During the pandemic, some SVHs found innovative ways to support veterans in their homes, including providing meals, telehealth, and home care visits. Given the flexibility and financial benefits to VA from partnering with State Veterans Homes, there are myriad possibilities for better addressing the changing demographics, needs and preferences of veterans today and in the future. Furthermore, SVHs already offer a number of medical and therapeutic services that could be provided on an outpatient basis for veterans participating in home-based programs.

With our expertise on the needs of aging veterans, SVHs could develop an array of home-based services to support veterans who want to age in their own homes. When they are no longer able to remain at home, SVHs could ease their transitions to facility-based skilled nursing care. Such an integrated non-institutional program could begin as a pilot program, with different states customizing it to meet local circumstances. NASVH recommends that the Committee consider establishing pilot programs to explore new arrangements for providing integrated non-institutional care programs through and in partnership with State Veterans Homes, offering a full spectrum of support from home care to skilled nursing care.

Strengthening NASVH-VA Partnership

Finally, to maximize the effective use of State Veterans Homes' resources and capabilities. VA must finally commit itself to a full and meaningful partnership with states. Too often, SVHs are an afterthought in VA's planning and budgeting processes. This is best exemplified by the continuing lack of representation by State Veterans Homes on VA's Geriatrics and Gerontology Advisory Committee (GGAC), despite NASVH having nominated multiple highly-qualified State Home administrators and leaders in recent years.

Mr. Chairman, State Veterans Homes can and must play a greater role in meeting aging veterans needs in partnership with VA and other federal agencies. NASVH looks forward to continuing to work with this Committee and your colleagues in the Senate to ensure that aging and ill veterans have greater access to a full spectrum of long term care options, whether at home or in nursing homes. That concludes my statement, and I would be pleased to answer any questions that you or members of the Committee may have.

U.S. Senate Committee on Veterans' Affairs Hearing**"An Abiding Commitment to Those Who Served: Examining Veterans' Access to LTC."****Testimony of Carla Wilton, Chief Operating Officer of Immanuel Lutheran Communities****June 7, 2023**

Good afternoon, Chairman Tester, Ranking Member Moran and members of the Senate Veteran's Affairs Committee. My name is Carla Wilton. I am the Chief Operating Officer for Immanuel Lutheran Communities in Kalispell, Montana. Immanuel Lutheran Communities is a full-service retirement community offering Independent Living, Assisted Living, Memory Support, Post-Acute Therapy Services and Long Term Care to 300 older adults. It is my pleasure to be here with you today.

I'd like to start by thanking Chairman Tester for representing Montana and for your advocacy to expand veteran's benefits to Assisted Living, particularly through the introduction of [Senate Bill 495 \(Expanding Veterans' Options for Long Term Care\)](#) earlier this year. This important legislation – supported by VA Committee Members Tester, Moran, Murray, Rounds and King – would create a commonsense approach to identifying and securing greater options and opportunities for Montana veterans to access important supportive long term care services.

On October 1, 2021, Immanuel Lutheran Communities was granted a Community Nursing Home (CNH) Indefinite Duration Indefinite Quantity (IDIQ) Contract with the VA. We typically have about 15 veterans in our building at any one time. Of the ones who are living on our campus, only eight of them qualify for the CNH contract. The remaining ones are only eligible for hospice contracts. Although the relationship between Immanuel and the VA has been a positive one, we do have a couple of concerns. The first is the timing of payments. The VA is the slowest to pay of all our payer sources. It is typically a month to a month-and-a-half behind in payments. We are currently owed February through April. There is a new nursing home program manager who is working to get up to speed on the program, but this does take time. Secondly, when a veteran moves into Immanuel, they must change their primary care provider to our medical director. However, if they need a referral to a specialist, we have to go back to a provider with the VA; our medical director cannot order that referral. This process often takes several weeks, causing the veteran and their family concern as they wait to be able to receive much needed care and services.

It is critical to note that over the course of the pandemic the nursing home sector in the United States [lost nearly 250,000 workers, 15% of our workforce](#) – and are struggling to recruit and rebuild. In Montana alone, we lost [1,070 of our 5,511 workers – nearly 20%](#). Immanuel experienced similar losses of team members during this period of time, as well. There were times when we were unable to admit new residents to the care center due to our inability to care for them because of low staffing numbers. In addition to raising staff wages almost 25% across the board, for the first time in our organization's 65-year history, we brought in agency

staff. Although this came at great expense, we have a responsibility to provide services to those living on our campus.

While many other health care sectors in the country have recovered, nursing homes still need [190,000 workers to return to pre-pandemic levels](#), which at the current pace, may not occur until late 2026. Staffing challenges in long term care existed prior to COVID-19, and the pandemic exacerbated them into a full-blown crisis. Caregivers are burned out after fighting the virus, there's a nationwide shortage of nurses, and nursing homes lack the resources to compete for workers due to chronic government underfunding. Nursing homes would love to hire more nurses and nurse aides, but we are currently grappling with a historic labor crisis, and the people are not there. Increasing staffing requirements as the Centers for Medicare and Medicaid Services (CMS) is considering doing at a time when we can't find the people to fill open positions is a dangerous policy. CMS is planning to release minimum staffing requirements for nursing homes at any time now, and this is simply not the time to do this. We need a comprehensive approach to recruit and retain long term caregivers – not an enforcement approach.

Earlier this year, Chairman Tester led a [bipartisan letter to CMS](#) on this very issue discouraging CMS from taking a "one-size-fits-all" approach and instead urged the Agency to address the significant workforce shortages affecting rural America. Thanks to the VA Committee members – including Senators Cramer, Manchin, Sinema and Rounds – for signing this important letter. I also must note that as is the case across the nation, 60% of our residents are on Medicaid. In Montana, Medicaid rates have historically been very low. In the 2021 legislative session, we received a 0.6% increase in our daily rate which equated to about \$1.25. As a result of decades of low reimbursement combined with the expense of the pandemic and difficulty in recruiting and retaining staff, 11 nursing homes in Montana closed during 2022. That was a reduction of nearly 15% of our total nursing homes across the state. Several of these were in rural communities that only had one nursing home to begin with. Their residents had to sadly leave their home to move to nursing homes far from family and friends.

As a result of these closures, there was much focus on Medicaid rates in this year's legislative session. We are still waiting for the Governor to sign the appropriations bill. Depending upon whether he chooses to line-item veto any of the increase, we anticipate coming out of this session with a rate of somewhere between \$253 - \$268. It costs us about \$350 per day to provide care and services to a resident. So, although we are grateful for this increase, we will still be losing \$80-\$100 dollars per day on our Medicaid residents.

The VA IDIQ contracted rate we currently have is based on the Medicaid rate. In Montana, the VA adds 16% to the Medicaid rate to come up with their rate. Once a new Medicaid rate is published, our rate with the VA will be somewhere between \$293 - \$310, which is getting closer to our costs, but still falls short. I understand that the VA is also offering Veterans Care Agreements – or VCAs – as an alternative to the IDIQ contracts we have. However, those nationally established rates based on a discount of Medicare may fall below the proposed new

Montana Medicaid rates, making it even more difficult for veterans to access community nursing home services in Montana.

All residents, including our veterans, are affected by low Medicaid reimbursements, which are set by states with little federal oversight despite the federal financial investment in these services. We believe that CMS should play a greater role in assuring the adequacy of state Medicaid rates and seriously consider whether the rates being paid reflect the reasonable costs associated with providing care in keeping with CMS's own regulations and health and safety standards. CMS should take a closer look at what it costs to provide nursing home care post COVID-19 and in light of the severe workforce shortages - and the unrestricted pricing of staffing agencies. It should ensure reimbursement from Medicaid and VA programs covers the cost of the care we are asked to provide and that our residents deserve.

Thank you for this opportunity to testify, and I am happy to answer any questions. I also invite you all to come tour Immanuel Lutheran Communities so you can see first-hand the wonderful individuals we serve and critical services we provide.

Questions for the Record

**Department of Veterans Affairs (VA)
Questions for the Record of a Hearing Titled
"An Abiding Commitment to Those Who Served: Examining Veterans'
Access to Long Term Care"
Committee on Veterans Affairs
United States Senate**

June 7, 2023

Questions from Ranking Member Jerry Moran

QUESTION 1: Is there a benefit to veterans who transition to a Community Living Center (CLC) that is co-located with existing VA facilities or other veteran-centric services as part of their community?

VA Response: A Veteran's unique situation in terms of medical needs, as well as social and familial support, should influence what and where the best environment is for that Veteran and their unique care needs. Providing Veterans with resources that are tailored to them and their experiences is always preferred. As evidenced by numerous peer-reviewed, cohort studies and systematic reviews regarding wellness of aging Veterans (e.g., Journal of Aging Research, American Psychological Association, Occupational Medicine publications¹), those Veterans who reside in locations with other Veterans realize many benefits, such as improved mood, appetite and quality of life based on being around individuals who have shared experiences (such as military service). Community living centers (CLC) that are co-located with existing VA facilities or other Veteran-centric services will have more opportunities for these experiences. Such CLCs also have more access to shared resources that can meet the unique needs of the aging Veteran population, including posttraumatic stress disorder (PTSD) and exposure-related illness, among others. CLCs often provide higher quality of care when compared to community nursing homes (CNH) due to the Veteran-specific training available to CLC staff as well as the supportive services available for Veterans in CLCs that are co-located with existing VA facilities or other Veteran-centric services.

- ¹: Flack, M., & Kite, L. (2021). Transition from military to civilian: Identity, social connectedness, and veteran wellbeing. PLOS ONE, 16(12), e0261634. <https://doi.org/10.1371/journal.pone.0261634>
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- Simons, K., Bower, E. S., Gillespie, S. M., & Mills, W. L. (2021). Care transitions to the community from veterans affairs nursing homes: experiences of social connection and disconnection. *Journal of the American Medical Directors Association*, 22(3), 682–688. <https://doi.org/10.1016/j.jamda.2020.07.029>
- Wilson, G., Hill, M. D., & Kiernan, M. D. (2018). Loneliness and social isolation of military veterans: systematic narrative review. *Occupational Medicine*, 68(9), 600–609. <https://doi.org/10.1093/occmed/kqy160>

QUESTION 2: Further to this point, if a CLC can be co-located among other veteran-focused benefits and services, such as healthcare services, would that CLC receive prioritization for implementation pursuant to Section 705 of the PACT Act that directs the Secretary to prioritize projects that provide “direct or indirect services or benefits” to veterans?

VA Response: Section 705 of the PACT Act is specific to projects that VA pursues under its Enhanced Use Leasing (EUL) authority (38 U.S.C. §§8161-8169, as amended). CLCs clearly provide direct Veteran benefits, so could be considered for implementation via VA’s EUL authority, through the VA EUL Program. However, EULs are not VA investments and we do not prioritize them as we do our own investments. These projects are funded, developed, constructed, operated and maintained by third parties, and can only be pursued on VA property that is vacant or underutilized and outleased to them. Hence, building a CLC via EUL could not be placed in a specifically designated area along with other medical services but could be part of an EUL on a VA site where medical services are present. Additionally, VA is prohibited from receiving any form of consideration other than cash in return for outleasing the property, so could not utilize the space to provide VA services. If implemented as an EUL project, the facility would not be considered a VA CLC, and VA could not be directly involved with it.

VA’s EUL Program partners with the local VA site once a potential EUL project to redevelop underutilized or vacant property has been identified. From there, a preliminary concept is developed and approved, a public hearing is held, and the opportunity is publicized to prospective developers via a Request for Proposals. If/when a developer is selected, the development process proceeds, including due diligence by both parties, until VA and the developer have reached agreement on detailed terms and conditions. VA informs Congress and Office of Management and Budget of the proposed project and executes the EUL agreement once any comments have been addressed. In short: If suitable underutilized/vacant property is available and VHA wishes to pursue a CLC at a particular site via EUL, it is ultimately up to the development community to evaluate the opportunity and respond with proposals for redeveloping the property, but VA could not operate the CLC.

QUESTION 3: Regarding infrastructure needs at VA and capacity for veterans in institutional settings, what is the long-term plan for institutional infrastructure within the VA as demand for long-term care services continues to grow?

VA Response: VA is committed to supporting an aging, complex Veteran population by improving geographical alignment of long-term care services with demand, improving access, enhancing Veteran-centric geriatric care models, modernizing aging CLC infrastructure, and managing costs. As part of VA’s long-term plan to effectively meet Veteran demand for long-term care services, VA will:

- Leverage expanded Home- and Community-Based Services (HCBS) to support Veterans’ interests and desires to age-in-place in their homes.

- Maintain and, as applicable, expand and modernize existing CLCs in markets with projected stability or growth in enrollees, established demand, and the ability to maintain a minimum number of CLC beds.
- Support the development of new, relocated, or expanded CLCs when there are market gaps or challenges to providing long-term care services for Veterans.
- Address the needs of complex, hard-to-place Veterans.
- Address the need for geropsychiatry services.
- Maximize the use of high-quality CNHs and State Veterans Homes to support Veterans along the long-term and extended care continuum while improving access to care close to home.
- Long Term Care Planning was evaluated during the first Quadrennial Market Area Health System Optimization (MAHSO) Assessments, which included a focused study on CLCs. The CLC National Planning Strategy was developed to establish planning guidelines that incorporate consideration of demand, supply, access, quality, and facilities and infrastructure.

Questions from Senator Patty Murray

The Planning for Aging Veterans Act, was included in the FY 23 omnibus package and instructed VA to look at how it is planning and preparing to care for our aging veteran population.

QUESTION 1: Has the department begun working to implement any of the aspects of this legislation, specifically the geriatric psychiatry care pilot program?

VA Response: VA will work with the National Association of State Directors of Veterans Affairs (NASDVA) and National Association of State Veterans Homes (NASVH) to establish the 2-year VA pilot program to provide geriatric psychiatry assistance to Veterans living at State Veterans homes. An Integrated Project Team (IPT) was established to plan pilot logistics, clinical intervention, and evaluation. VA is on track to commence the pilot by the end of the calendar year 2023.

Additionally, pursuant to section 164 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (the Cleland-Dole Act), VA is working with public housing authorities and local organizations to assist aging homeless Veterans in accessing existing housing and supportive services.

QUESTION 2: Has VA utilized the additional authority to support veterans who seek care in medical foster homes? If so, how successful has that been?

VA Response: VA appreciates the new authority afforded in the Cleland-Dole Act to allow for payments for select Veterans in Medical Foster Homes (MFH). VHA is currently working on administrative aspects to allow for this payment to MFH caregivers, including creation of standardized agreements, new data systems, and fee schedules. In addition, VHA is expanding the MFH program to all VA medical centers to allow access and choice for Veterans in more geographic locations across the country by the end of fiscal year (FY) 2025.

Questions for the Record from Senator Kevin Cramer

QUESTION 1: Mr. Saslo, an important step in delivering increased choice and access for veterans long term care is improving the collaboration between the VA and non-VA facilities. I hear from facilities in my state interested in serving veterans, but struggle with the complicated contracting process and duplicative requirements across various federal agencies such as the Centers for Medicare & Medicaid Services (CMS) or the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP). How can the VA simplify and reduce redundancies to improve the process for facilities to participate in VA arrangements and care for our veterans?

VA Response: VA allows CNHs to submit a proposal for an Indefinite Delivery Indefinite Quantity (IDIQ) contract or to request a Veterans Care Agreement (VCA) based on their own analysis of the advantages and disadvantages of each. VCAs are exempt from the Service Contract Act and also reduce administrative burden for VA facilities and nursing homes when compared to IDIQ contracts. However, at this time the payment rate is often higher on an IDIQ contract.

In recent years, VA has endeavored to move away from nursing home inspections and focus our efforts on assessing the quality of care provided to individual Veterans. This shift in approach allows VA staff more time to assist Veterans with care coordination and discharge planning. It also allows VA staff more time to advocate for Veterans and do what we can to improve the Veterans' experience at the nursing home.

VA values the work of the Centers for Medicare & Medicaid Service (CMS) and State Survey Agencies (SSA). VA uses SSA reports and the data on CMS' Nursing Home Compare website to help determine whether to initiate or continue a contract or VCA with a nursing home. The quality of care for the Veterans in the facility and the Veterans' experience in the facility are also vital factors in VA's determinations.

Questions for the Record from Senator Tommy Tuberville

QUESTION 1: Dr. Saslo, can you please discuss the Redefining Elder Care in America Project pilot and how it's using predictive analytics to identify veterans at highest risk for nursing home admission?

VA Response: The Redefining Elder Care in America Project (RECAP) pilot seeks to proactively identify high-risk Veterans, engage home and community-based services, and support their remaining in the community. The RECAP pilot is active at three VA sites. Key components of RECAP are a) predictive analytics using available data; b) dedicated staff to assess Veteran and caregiver needs; and c) enrollment in appropriate home- and community-based services (HCBS) and longitudinal follow-up. The predictive analytics tool uses available data to predict long-term institutionalization and stratifies Veterans into high-, medium-, and low-risk for long-term institutionalization.

QUESTION 2: What indicators, or factors, are you using as part of the model to determine which veterans may be in need?

VA Response: The predictive tool utilizes Veteran demographics, diagnoses and diseases, health care utilization (urgent care, emergency department, and hospitalizations), and mental health diagnoses to stratify Veterans into high-, medium-, and low-risk categories. The RECAP clinic team utilizes several screening tools in their assessment: family caregiver demographics and length of time spent in the role, Zarit 4 question Caregiver Burden screen, VA Case Mix Tool, Lawton-Brody Instrumental Activities of Daily Living assessment, and the Brief Resiliency Scale. Together, these assessments provide an overall assessment of the Veteran's level of functioning within their home environment as well as the burden placed on the family caregiver. The RECAP clinician assimilates the information from the assessment to determine the most appropriate HCBS for the Veteran.

QUESTION 3: Is this model being used in every state? How successful has it been in identifying veterans for nursing homes?

VA Response: The RECAP pilot is deployed to three facilities (Lee County, FL Health Care Center, Fayetteville, NC Health Care Center, and North Little Rock, AR Health Care Center) that were identified based on their older population, availability of HCBS, and engagement of VA medical center leadership. The RECAP pilot has only been in operation for 18 months and has successfully identified Veterans with functional deficits and burdened family caregivers, two primary factors for long-term institutionalization.

Questions for the Record from Senator Dan Sullivan

QUESTION 1: Approximately 80% of veterans will develop the need for long-term services and supports during their lifetime. In Alaska, we excel at providing Home- and Community-Based Services (HCBS). These services allow individuals to age in their own homes, resulting in better outcomes, happier patients, and ultimately lowering the cost of care. That said, oversight of these services, as well as long-term care facilities is incredibly important.

I'm concerned about how oversight and one-size-fits all requirements for long-term care impact Alaska. For example, we have reached out to CMS multiple times to discuss the minimum of five rule. This rule requires states to survey either 5% of facilities or a minimum of 5 facilities a year. In Alaska, we have less than 20 facilities state-wide, making 25% of our facilities surveyed each year. We are the only state with this problem because we have the fewest facilities in the nation.

As the VA is implementing long-term care oversight policies, how are you thinking about rural states, like Alaska, that may have a hard time with minimum staffing requirements or policies like the "minimum of five" rule, that are meant to be helpful oversight, but frankly result in overregulation and burnout?

VA Response: VA defers to CMS to comment on the CMS requirements for SSAs. In VA's CNH Program, the Office of Geriatrics and Extended Care works closely with the Alaska VA Healthcare System. Special considerations have been made related to the geographical and transportation challenges faced by staff completing oversight tasks within Alaska.

Questions for the Record
Senate Veterans' Affairs Committee
An Abiding Commitment to Those Who Served:
Examining Veterans' Access to Long Term Care
Wednesday, June 7, 2023

Sen. Dan Sullivan

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Are you aware of this situation in Alaska? Will you commit to working with my office and the state of Alaska on a solution for our state to address the minimum of five? What Administrative flexibilities are available for Alaska?

Answer:

This rule is a statutory requirement. Section 1819 (g)(3) of the Social Security Act requires that CMS perform validation surveys on at least 5 percent of the number of skilled nursing facilities surveyed by a State in a year, but in no case less than 5 skilled nursing facilities in the State annually. If you are interested in drafting legislation to address this issue, CMS would be happy to provide technical assistance.

Sen. Tommy Tuberville

1. Mr. Blum, the Centers for Medicare and Medicaid Services (CMS) recently announced that it is going to begin auditing Alabama’s medical rehabilitation hospitals later this summer through a demonstration called the Inpatient Rehabilitation Facility Review Choice Demonstration, or IRF RCD. Several of my colleagues and I have previously communicated our concerns to your agency about this audit. This is going to be very tedious for medical rehabilitation hospitals and their caregivers. Rehabilitation physicians, nurses, and therapists are going to have more paperwork and administrative burdens put upon them because of it. I’m concerned that the impacts of programs like this may discourage caregivers from coming back into healthcare workforce and may encourage some of them to leave this field of medicine and patient care altogether.

I’m also concerned that this demonstration’s impact may jeopardize my constituents’ access to rehabilitation hospital care, especially if delays in care or inappropriate denials occur as part of it.

How does CMS plan to administer this extra administration workload for these facilities given the ongoing workforce shortage?

Answer:

The Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility (IRF) Services will provide flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules. The IRF RCD is intended to reduce the number of Medicare appeals, improves provider compliance with Medicare program rules, does not alter the Medicare IRF benefit, and should not delay care to Medicare beneficiaries.

Beginning August 21, 2023, CMS will implement the RCD for IRF services in Alabama. IRF providers can make their review choice selection of either 100% pre-claim review or 100% postpayment review at the Palmetto GBA Provider Portal¹ between July 7 and August 6, 2023. After a 6-month period, IRFs demonstrating compliance with Medicare rules through their pre-claim review affirmation rate or postpayment review approval rate will have additional review choices to select from (including selective postpayment review and spot check prepayment review, giving IRFs more flexibility as an incentive for enhanced compliance.

CMS will continue to work with stakeholders to provide IRFs with the tools they need to successfully comply with IRF RCD requirements, including through efforts to solicit public feedback, such as open door forums. More information including an Operational Guide and Process Flow Chart are available at: <https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-inpatient-rehabilitation-facility-services>.

¹ Palmetto GBA Provider Portal https://www.onlineproviderservices.com/ecx_improvev2/

2. Mr. Blum, we are experiencing a severe workforce shortage across the health care industry, not just in VA facilities. While my colleagues often discuss the workforce shortage through the lens of COVID, the health care system in Alabama has been suffering from a shortage of health care workers for decades. A huge part of that issue is due to how our providers and hospitals are reimbursed through CMS. And under the current Medicare Area Wage Index formula, Alabama has the lowest wage index in the country.

How are Alabama providers supposed to recruit and retain employees when they automatically make much less money than they could right across the state line for the same work?

Answer:

CMS is committed to promoting Medicare payment accuracy and hospital stability. The Social Security Act requires that, as part of the methodology for determining prospective payments to hospitals, the standardized amounts for area differences in hospital wage levels are adjusted by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. This adjustment factor is the wage index, which must be updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation.

In computing the wage index, we derive an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. In applying the law, CMS strives to ensure access for all beneficiaries while maintaining incentives for the agency's hospital partners to operate efficiently.

To help mitigate wage index disparities between high wage and low wage hospitals, in the FY 2020 Hospital Inpatient Prospective Payment System (IPPS) final rule, CMS adopted a policy to increase the wage index values for certain hospitals with low wage index values (the low wage index hospital policy). This policy was adopted in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. CMS also indicated its intention that this policy would be effective for at least 4 years, beginning in FY 2020, in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. In the FY 2024 IPPS proposed rule, CMS proposed to continue the low wage index hospital policy. CMS will consider all interested party comments that were submitted in response to this proposal in developing the final FY 2024 IPPS rule.

CMS looks forward to working with the Alabama Congressional delegation and other stakeholders as it looks at innovative ways to prevent future hospital closures and expand access to care across the country.

Sen. Kevin Cramer

1. Mr. Blum, nearly every industry continues to face significant staffing challenges and the health care sector is no exception. Among the various health care settings, long term care facilities have encountered a particularly difficult and competitive labor market over the past several years. In 2022, 90% of nursing facilities in North Dakota relied on contract labor to fill critical staffing needs, more than doubling the cost of contract staff compared to 2021. During the pandemic, North Dakota experienced the closure of several nursing facilities due to these staffing challenges. Despite this difficult environment, North Dakota nursing facilities have continued to strive forward and continued to deliver the quality services we've come to expect. As you consider imposing any form of staffing ratios, I urge you to re-evaluate the impact such a proposal would have on senior's access to care, especially in rural areas. We need to address the pipeline of health care workers moving into the industry while avoiding inflexible top down mandates. In your testimony to the committee, you explicitly mentioned sending a clear signal to nursing homes regarding the requirements of CMS, which you said if not met, will result in less access and more facilities closing. While you clarified that you had misspoken, can CMS definitively say this policy will not result in facility closures? Has CMS thoroughly considered the impact of staffing mandates as it directly relates to the potential closure of rural facilities or substantially increased costs to operate nursing facilities as a result?

Answer:

CMS is working hard to support the Administration's plan to improve safety and quality of care in the nation's nursing homes, and we remain committed to proposing minimum staffing standards for nursing and skilled nursing facilities. We know that adequate staffing is the most important measure for improving care for nursing home residents, and it is important to us that we hold facilities accountable if they are failing to provide appropriate care to their residents.

In the FY 2023 SNF PPS proposed rule, CMS solicited public comments on minimum staffing requirements. We appreciate the comments we received in response to the request for information. Additionally, CMS launched a new mixed-methods study in August 2022 collecting quantitative and qualitative evidence on staffing levels within nursing homes. CMS continues to review the feedback and evidence from both the comment solicitation and mixed-methods study. It is CMS's goal to consider all perspectives, as well as findings from the staffing study, to inform proposals on minimum staffing requirements that advance the public's interest of safe, quality care for residents.

2. On a similar note, the ability of nursing facilities to conduct training and develop new staff for positions such as Certified Nursing Assistants, is an extremely valuable tool, especially in light of the current workforce challenges. That's why it's so troubling to hear examples of CMS imposing penalties and restricting the ability of facilities to conduct such training. As CMS weighs imposing new staffing burdens on nursing facilities, what is the agency doing to support and remove barriers for nursing facilities to conduct their own training programs?

Answer:

CMS does not impose penalties or otherwise restrict a facility's ability to operate a nurse aide training competency and evaluation program (NATCEP). Instead, CMS imposes penalties to remediate noncompliance as part of our obligation to keep residents safe. As required by sections 1819(f)(2)(B)(iii)(I)(c) and 1919(f)(2)(B)(iii)(I)(c) of the Social Security Act, a facility may not operate a nurse aide training program if it has been imposed a civil money penalty (CMP) of over \$5,000 (this figure is annually adjusted for inflation, and is currently about \$10,000) in the past 2 years. CMS does not have discretion over whether to implement this provision of law.

However, CMS and states do have some discretion to waive the restriction on training after it is triggered, including if: (1) there is no other such program offered within a reasonable distance of the facility and the state assures through an oversight effort that an adequate environment exists for operating the NATCEP in the facility; or (2) the imposition of the civil monetary penalty was not related to the quality of care provided to the residents. CMS has encouraged nursing homes to explore obtaining a waiver to help them retain their ability to conduct a training program following a sufficiently large CMP.

Statements for the Record



Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

**United States Senate Committee on Veterans' Affairs
Hearing on "An Abiding Commitment to Those Who Served: Examining Veterans' Access
to Long Term Care"**

June 7, 2023

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Committee on Veterans' Affairs hearing on "An Abiding Commitment to Those Who Served: Examining Veterans' Access to Long Term Care." The Association and AIM thank the Committee for its continued leadership on issues important to the millions of veterans living with Alzheimer's and other dementia and their caregivers. This statement highlights the importance of policies that will help ensure a quality workforce at the Department of Veterans Affairs Veterans Health Administration (VHA) that is able to meet the needs of our nation's growing number of veterans living with Alzheimer's and other dementia.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

The Alzheimer's Association and AIM are deeply grateful for the VA's comprehensive approach to dementia and the people it affects. We applaud the recent decision by the VHA to provide coverage of the Food and Drug Administration (FDA)-approved lecanemab (Leqembi) used to treat individuals living with mild cognitive impairment and Alzheimer's disease. In addition, the Department's extensive research, its care and support services within the Geriatrics and Extended Care program, and its participation in the Advisory Council on Alzheimer's Research, Care, and Services are greatly appreciated.

Nearly half a million American veterans have Alzheimer's — and as the population ages, that number is expected to grow. In 2015, an estimated 486,000 veterans were living with Alzheimer's. The annual number of veterans newly diagnosed with dementia has increased by more than 22 percent since 2008. For veterans, the prevalence may grow even faster in future years because they have a higher risk of developing dementia. The significant increase in the

number of veterans with Alzheimer's and other dementias will place a heavy burden on the VA health care system, and in turn, long-term care settings.

As the rate of Alzheimer's and dementia among veterans increases, so does the need for access to care and support services for these individuals and their caregivers, and members of the paid dementia care workforce. We encourage the Committee to consider the following recommendations to improve long-term care and support for the growing number of veterans affected by Alzheimer's.

Supporting the Direct Care Workforce in Long-Term Care Settings

While people living with Alzheimer's and other dementia and their caregivers often prefer to keep the individual living in the home for as long as is manageable, they make up a significant portion of all long-term care residents, comprising 48 percent of residents in nursing homes and 34 percent of all residents in assisted living communities and other residential care facilities. Twenty-four percent of Medicare beneficiaries with Alzheimer's or other dementias reside in a nursing home, compared with one percent of Medicare beneficiaries without these conditions. Approximately 75 percent of individuals with Alzheimer's disease diagnosed at age 70 will reside in a nursing home by age 80, compared with only four percent of the general population surviving to age 80. Given our constituents' intensive use of these services, the quality of this care is of the utmost importance.

As the prevalence of Alzheimer's disease increases, so does the need for members of the paid dementia care workforce. Shortages in direct care workers in long-term care settings will place an even bigger burden on family and friends who provide unpaid care — already an effort equivalent to nearly \$257 billion per year. The United States will have to nearly triple the number of geriatricians to effectively care for the number of people projected to have Alzheimer's in 2050, while efforts to increase recruitment and retention remain slow. In 48 U.S. states, double-digit percentage increases in home health and personal care aides will be needed by 2028 to meet demand. From 2016 to 2026, the demand for direct care workers is projected to grow by more than 40 percent, while their availability is expected to decline.

The [*Alzheimer's Association's Dementia Care Practice Recommendations*](#) include the following recommendations specific to workforce: (1) staffing levels should be adequate to allow for proper care at all times — day and night; (2) staff should be sufficiently trained in all aspects of care, including dementia care; (3) staff should be adequately compensated for their valuable work; (4) staff should work in a supportive atmosphere that appreciates their contributions to overall quality care because improved working environments will result in reduced turnover in all care settings; (5) staff should have the opportunity for career growth; and (6) staff should work with families in both residential care settings and home health agencies. Additionally, we know that consistent assignment is an important component of quality care for staff working with residents with dementia.

While much of the training for long-term care staff is regulated at the state level, we encourage the Committee to consider proposals that support state VHA Medical Centers in implementing and improving dementia training for direct care workers, as well as their oversight of these activities. Training policies should be competency-based, should target providers in a broad range of settings and not limited to dementia-specific programs or settings, and should enable staff to (1) provide person-centered dementia care based on a thorough knowledge of the care recipient and their needs; (2) advance optimal functioning and high quality of life; and (3) incorporate problem-solving approaches into care practices.

We also urge the Committee to support VHA Medical Centers in the following efforts: (1) any training curriculum should be delivered by knowledgeable staff that has hands-on experience and demonstrated competency in providing dementia care; (2) continuing education should be offered and encouraged; and (3) training should be portable, meaning that these workers should have the opportunity to transfer their skills or education from one setting to another.

Again, the Alzheimer's Association and AIM look forward to working with the Committee to shape specific proposals to better train and support the direct care workforce at the VA. In the meantime, we encourage you to keep veterans living with dementia top-of-mind as you continue this important work.

Home- and Community-Based Services: The Impact on Family Caregivers and Needs of the Alzheimer's and Dementia Community

We are grateful for the Department of Veterans' Affairs' commitment to supporting veterans living with Alzheimer's and other dementia by offering an array of long-term care and support services, such as assisted living, residential, as well as adult day and home health care.

Home- and community-based services (HCBS) allow people with dementia to remain in their homes while providing family caregivers with much-needed support. These services empower caregivers to provide quality care for their loved ones while giving them an opportunity to manage and improve their own health.

While 83 percent of care provided to older adults in the United States comes from family members, friends, or other unpaid caregivers, nearly half of these caregivers do so for individuals with Alzheimer's or other dementia. Of the total lifetime cost of caring for someone with dementia, 70 percent is borne by families — either through out-of-pocket health and long-term care expenses or from the value of unpaid care. In 2022, more than 11 million unpaid caregivers provided an estimated 16 billion hours of unpaid care to people with Alzheimer's and other dementias, at an economic value of over \$271.6 billion.

Several states are implementing innovative solutions to address Alzheimer's by developing critical, cost-effective, dementia-specific HCBS programs. These programs are allowing people with dementia and their caregivers to access services and support that are uniquely tailored to meet their needs, allowing them to remain in their homes and communities longer and enjoy a greater quality of life. The VHA should consider adopting a core set of home- and

community-based services that are specifically designed for people with dementia. A core set of HCBS, in addition to other services, will allow people with Alzheimer's to continue to remain in their communities and be independent for as long as possible.

We are grateful the Committee unanimously passed S. 10, the VA Clinician Appreciation, Recruitment, Education, Expansion, and Retention Support (CAREERS) Act, as well as S. 141, the Elizabeth Dole Home Care Act of 2023, which aim to improve and expand the VA health care workforce and expand home and community-based services (HCBS) for disabled and elderly veterans. As you know, these resources are critical in serving the needs of our constituents, including those who have served in uniform.

Conclusion

The Alzheimer's Association and AIM appreciate the Committee's steadfast support for veterans and their caregivers and the continued commitment to advancing issues important to the millions of military families affected by Alzheimer's and other dementia. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance policies that will ensure individuals living with Alzheimer's and other dementia have adequate access to high-quality long-term care services at the Department of Veterans' Affairs, especially as the population of veterans living with dementia continues to grow.



June 7, 2023

Honorable Jon Tester, Chairman
U.S. Senate Committee on Veterans' Affairs
825-A Hart Senate Office Building
Washington, D.C. 20510-6050

Honorable Jerry Moran, Ranking Member
U.S. Senate Committee on Veterans' Affairs
412 Russell Senate Office Building
Washington, D.C. 20510-6050

Dear Chairman Tester and Ranking Member Moran:

On behalf of the American Seniors Housing Association (ASHA), I want to thank you for holding this important hearing, ***"A Binding Commitment to Those Who Served: Examining Veterans Access to Long Term Care"***. As we know all too well, the long-term care needs of our aging population are a national concern, and we commend your attention to assessing the state of VA programs and services that are currently available to our cherished veteran community.

ASHA is a national organization of over 500 companies involved in the operation, development, investment, and financing of the entire spectrum of seniors housing – independent living, assisted living, memory care, and Continuing Care Retirement Communities (CCRCs). Our members are on the front lines when it comes to serving frail seniors by providing 24/7 expert care, supportive services, dining, housekeeping and myriad activities that promote wellbeing and social interaction. As providers of long-term care, we are pleased to offer our thoughts and recommendations to create additional supportive care options for our veterans.

The Department of Veterans Affairs (VA) provides or purchases long-term care for eligible veterans through 14 long-term care programs in institutional settings like nursing homes and noninstitutional settings such as home-based care. However, as noted in a report by the Department of Veterans Affairs to Congress¹, there is much concern over the projected future needs of the veteran population and the sustainability of the existing programs. The report correctly calls for the VA to explore additional options to serve aging and disabled veterans including the utilization of assisted living settings.

As you review the effectiveness of these programs and services, we would like to commend your leadership as well as Senator Murray and Senator Rounds, on the introduction of S. 495, the ***"Expanding Veterans' Options for Long Term Care Act"***. We would also like to call attention to this bill to the members of the Senate Veterans Affairs Committee as consideration is given to the current VA long term care programs and future needs.

The proposed three-year pilot program to assess the effectiveness of providing eligible veterans with the option to move into an assisted living community for their supportive care services is an economically sound and sensible approach to demonstrate the benefits of assisted living for the veterans as well as their families. ASHA strongly believes assisted living offers the best of personal and supportive care services with a team of professionals in a home environment where individuals can

¹ *Veterans' Use of Long-Term Care is Increasing, and VA Faces Challenges in Meeting the Demand*, February 2020
<https://www.gao.gov/assets/gao-20-284.pdf>

continue to live a meaningful life that promotes social engagement, nutrition, and wellbeing. This pilot program is designed to assess not only the effectiveness of the setting itself, but the satisfaction of resident veterans. Other details of the bill underscore the thoughtful approach to this effort. Locations will be geographically diverse, will include rural areas, and areas where the largest concentration of veterans live. The pilot will also include assisted living settings in at least 2 VA state homes. While the pilot may be small in scope, the benefits can be significant to understanding options available that will help to meet the future demand for long term care options. We commend your leadership in leading and advancing this bill this year.

The timing is right for such action given what we know about the aging population and the increasing demand for supportive services.

Aging Demographics Demand Additional Long Term Care Options for Veterans

- As reported by the VA, the fastest growing segment of the Veteran population are those veterans over the age of 85. Further, the number of veterans eligible for nursing home care will increase 535%, from 62,000 to 387,000, over the next 20 years.
- The overall 85 and older population is projected to more than double from 6.6 million in 2019 to 14.4 million in 2040 (a 118% increase).
- Approximately 5% of Veterans in Community Nursing Homes (CNH) at VA expense do not require daily skilled nursing interventions.
- The increasing prevalence of chronic conditions will drive up demand for long-term care services, including assistance with the activities of daily life (ADLs).
- A 65-year-old today has almost a 70% chance of needing some type of long-term care services and supports in their remaining years and will need it for an average of 3 years. Twenty percent are projected to need long-term care for five years or more.

Simply put, people are living longer, there are more of them, and they are more fragile. For those who will need long-term care, they will on average incur \$138,000 for these services. These projections are especially concerning for those seniors who are unprepared financially. Nearly 4 in 10 mistakenly expect to rely on Medicare to pay for their long-term care needs and 1 in 3 have done little to no planning for their own care needs. As a country we must prepare for this demand for long-term care options and this bill presents an opportunity to highlight through this pilot program, the critical need for quality settings such as assisted living that are also cost effective.

Cost of Care Varies Among Settings:

As stated above, the demand for assisted living is growing, the benefits are many, and the average annual costs are among the lowest of Long-Term Care Services (LTCSS) options and therefore beneficial to taxpayers. Senior living covers a range of service-enriched housing aimed at older adults who want or need specific service amenities or help with activities of daily living. They differ from nursing homes in purpose, levels of care, residences, and lifestyle. Importantly, it is the most cost-efficient setting available to our seniors today. The desired goal is for these services to help people live as independently and safely as possible when they can no longer perform everyday activities on their own. Assisted living does just that.

According to the 2021 Genworth Annual Cost of Care Report, the median monthly and annual costs for the selected settings are as follows:

Provider	Setting	Monthly Cost	Yearly Cost
Home Health Care (44 hours per week/52 weeks)	Homemaker Health Aide	\$ 5,148	\$ 61,776
Assisted Living Community (12 months of care/housing)	Private, One Bedroom	\$ 4,500	\$ 54,000
Nursing Home Care (365 days of care)	Semi- Private Room	\$ 7,908	\$ 94,896
	Private Room	\$ 9,034	\$ 108,408
Adult Day Health Care (5 days per week/52 weeks)	Day Program	\$ 1,690	\$ 20,280

While the median cost for assisted living is clearly lower than the median costs of home health care, it is also important to note the differences in these settings. The cost of assisted living is inclusive of meals, care, private apartment, activities, transportation, and other services. The median cost for a home health aide is limited to services provided 44 hours per week. It does not include meals and activities and the ongoing costs of maintaining a home, i.e., mortgage or rent, repairs, utilities etc. will remain the responsibility of the client. Under this pilot program, after factoring in a higher payment rate that will include room and board, the savings are expected to be significant.

As you assess policies and programs to address the long-term care needs of aging veterans, we ask that you not overlook the benefits of senior living, and support S. 495. Given current and projected needs for VA long term care services, efforts to rebalance these programs have the potential to yield significant benefits to the veterans as well as result in overall cost savings for long term care.

On behalf of the senior living industry, I thank you for your work in taking bold action to improve the lives of our nation's veterans at a time when they need it the most. If you have any questions, please reach out to Jeanne McGlynn Delgado, ASHA VP, Government Affairs at jeanne@ashaliving.org. We look forward to working with you to advance this important option of care for veterans.

Sincerely,



David Schless
President & CEO

CC: Senate Veterans Affairs Committee Members

**STATEMENT FOR THE RECORD
ELIZABETH DOLE FOUNDATION
FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS
LEGISLATIVE HEARING
JUNE 7, 2023**

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for the opportunity to provide a written statement for today's hearing, "An Abiding Commitment to Those Who Served: Examining Veterans' Access to Long Term Care." This topic is very timely, and we are grateful to contribute to the discussion.

The Elizabeth Dole Foundation is the preeminent organization empowering, supporting, and honoring our nation's military caregivers; the spouses, parents, family members and friends who care for America's wounded, ill or injured veterans. The Foundation was born out of Senator Elizabeth Dole's conversations with caregivers while Senator Bob Dole was receiving care at Walter Reed Medical Center, and she realized that not enough was being done for military and veteran caregivers. Senator Elizabeth has since made the transition from caregiver to survivor after her husband's passing in 2021, but she remains steadfast in her advocacy on behalf of caregivers.

Significance of Long-Term Care

[Experts predict](#) that by 2050, there will be an estimated 1.5 billion people aged 65+ worldwide—a sharp increase from 703 million in 2019. Within the military population, the [combat mortality rate](#) fell from 55% in World War II to 12% during the conflicts in Iraq and Afghanistan. Through a combination of improved medicine, technology, and equipment, more servicemembers are surviving catastrophic injuries and are able to return home.

Further, while institutional long-term care is necessary option for veterans of all age groups, we know that a significant majority of older Americans (and veterans) prefer to age in place. A [study conducted by AARP](#) found that 76% of people aged 50 or older would prefer to remain in their current home for as long as possible, which ultimately requires support from a caregiver. These trends all point to the growing need to invest in home and community-based services and the caregivers who step into this role.

As remaining in the home becomes more popular, research shows that it is more than just a fiscally responsible choice. Not only can veterans maintain their autonomy, but they are able to thrive and receive care in a setting that is familiar to them. According to the National Institute of Health, combating loneliness in elderly adults is critical to maintaining their health. [Research conducted by AARP](#) shows that social isolation and loneliness increases the risk of stroke by 32% and dementia by 50%. The United States spends [more than \\$6.7 Billion](#) annually through Medicare as a result of conditions exacerbated by social isolation.

To support all veterans who seek to age in-place, and relieve strain on VA's institutional long-term care infrastructure, we invite the committee to make themselves aware of VA's Geriatrics and Extended Care case mix index tool. We are concerned that the current implementation of this tool is prohibiting some veterans from utilizing concurrent VA services, which places a larger burden on veteran caregivers, especially those caring for older veterans. Overall, it is imperative for VA programs that support veterans at home to work together in coordination with one another to achieve best clinical outcomes, be economically responsible, and ensure that family caregivers are supported.

We are encouraged by programs like VA's Clinical Resource Hubs, which allow veterans to access medical services within their own homes with assistance from those that they trust. Facilitated through medical equipment sent to the veteran's home, their doctor can conduct physicals and check vital signs without being there in person. For severely immunocompromised veterans and veterans living in rural areas, programs like these are life-changing.

Due to advancements like these, veterans are able to access comprehensive care now more than ever. We can imagine the impacts on long-term care if more investments were made in this area. This model is the future of healthcare, and we applaud the Congress for introducing legislation to help foster this growth, specifically with *The Elizabeth Dole Home Care Act*.

Significance of *The Elizabeth Dole Home Care Act*

In May 2023, the Senate held a cloture vote for the *Elizabeth Dole Veterans Programs Improvement Act*. Despite the legislation's popular contents to improve and reform support for caregivers and veterans nationwide, the package ultimately fell a few votes short. The Foundation, as well as other supporters of the proposal, were disappointed in this outcome and remain steadfast in our efforts in shepherding it across the finish line. Here's why:

Not only are people living longer, but they are also more likely to have chronic health conditions that require regular care—care that often falls to family caregivers. In 2014, [research conducted by RAND](#) and commissioned by the Elizabeth Dole Foundation found that there are approximately 5.5 million military and veteran caregivers in the United States that provide \$14 billion annually in unpaid labor, caring at home for their veteran loved ones. With inflation, this equates to approximately \$20 billion today. In a more recent [study conducted by AARP](#), researchers estimated that throughout the country, family caregivers provide \$600 billion in unpaid work every year.

Despite caregivers in the US creating a larger economy than the entire country of Sweden, there remains a lack of support for themselves and their families. This hearing, in addition to other important efforts across government, represents a critical opportunity to bring much-needed support for veteran caregivers nationwide.

The version of *The Elizabeth Dole Home Care Act* [as introduced during the 117th Congress](#) included the following critical provisions:

- Increase the non-institutional expenditure cap from 65% to 100%.
- Expedite and expand access to the Department of Veterans Affairs (VA) Home and Community-Based Services (HCBS) to all Medical Centers, including those in the U.S. territories, in two years. Services include:
 - The Veteran Directed Care Program – Provides veterans a flexible budget to hire friends, family, and neighbors to help with activities of daily living.
 - The Home Maker Home Health Aide Program – Allows VA to contract with a community partner that employs home health aides to care for veterans in their homes.
 - The Home-Based Primary Care Program – For a veteran who has difficulty traveling, is isolated, or whose caregiver is burdened, a VA physician will supervise healthcare in the veteran's home.
 - The Purchased Skilled Home Care Program – For veterans who have higher levels of need the VA will contract with a community agency to provide skilled nursing care in a veteran's home.

- Require VA to continue working with caregivers if they are denied from a program to find an alternative. VA must inform caregivers of other services they can access and ensure they are connected to appropriate resources.
- Expand access to respite care for family caregivers of veterans enrolled in home care programs.
- Establish a “one stop shop” webpage to centralize information for families and veterans on all programs and includes an informational eligibility assessment tool.
- Mandate stronger coordination between the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and VA’s other services. If a veteran is denied or discharged from PCAFC, the veteran must be assessed for participation in all other HCBS programs.
- Establish a three-year pilot program to address shortages of home health aides. VA will directly hire or repurpose current nursing assistants to be home health aides for veterans.

One provision within this legislation that has received significant attention is the section that would increase the non-institutional expenditure cap from 65% to 100%. As written in greater detail in our previous [Statement for the Record](#), the non-institutional care expenditure cap is VA’s ability to pay providers of in-home health care services up to 65% of the total cost to the VA if it had provided care within a VA facility (38 U.S.C. § 1720C(d) (1997)). Increasing the cap would ease the economic burden placed on caregivers and allow for their loved ones to remain in the home.

The Congressional Budget Office (CBO) estimated that this section would cost \$24.5 billion over ten years. Due to this provision contributing to the vast majority of the bill’s total cost, it has become the subject of debate and was consequently removed from the Senate version of the bill. The Elizabeth Dole Foundation, along with many VSOs and organizations that serve family caregivers, believes this initial cost estimate is artificially high because this program ultimately serves a small, acute population of veterans and their caregivers—closer to several hundred veterans and not thousands. Due to this, we and a coalition of our partners are working with the House Veterans Affairs Committee to see a House version re-scored so that the provision removing the cap is included in the final version of this legislation. When considering this cap and healthcare programs for veterans and caregivers overall, we urge the Committee to make determinations on clinical need and not based on an arbitrary coverage figure.

This bill, if passed, would have a profound impact on our nation’s military and veteran caregivers, as well as the loved ones they care for. Not only would caregivers have increased access to the full array of support that the VA offers, but they also would be able to access them within their own communities. Additionally, this robust investment in long-term care would assist in easing the economic burden placed on the caregivers and families of those who are aging in place and need advanced care. By increasing the non-institutional expenditure cap, veterans can age with dignity and receive treatment where they feel most comfortable.

Since its reintroduction this year in the Senate, the *Elizabeth Dole Home Care Act* (S. 141) has been added to a package that contains four other bills. This package has been renamed to the *Elizabeth Dole Veterans Programs Improvement Act*, and contains the following proposals along with *The Elizabeth Dole Home Care Act*:

- S. 106, the Commitment to Veteran Support and Outreach Act
- S. 185, the Native American Direct Loan Improvement Act of 2023
- S. 216, the RESPECT Act of 2023
- S. 326, the VA Medicinal Cannabis Research Act of 2023

Congress has the opportunity to support our nation's military and veteran caregivers through this holistic piece of legislation. The Senate should bring this legislation to the floor for a vote and continue working with the House to ensure that it becomes law.

Conclusion

Through multiple hearings, press conferences, and pieces of legislation, the 118th Congress has shown the veterans and their caregivers that long-term care is a priority. It is absolutely critical that we take this opportunity to enact meaningful reforms that prioritize the needs of our aging veteran population and their acute medical needs. This Congress must act to build a long-term care system that is accessible, affordable, person-centered, and sustainable—ensuring that all Americans can age with grace, dignity, and the support they deserve.