Statement of Jade Gong
Principal, Health Strategy Associates
Member, Geriatrics and Gerontology Advisory Committee
Before the Committee on Veterans' Affairs
U.S. House of Representatives

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Dear Mr. Chairman and Members of the Committee:

Thank you for inviting me to present my views on how to meet the long term care needs of aging Veteran's over the next 10 years. Although I currently serve on the Geriatrics and Gerontology Advisory Committee to the Secretary of Veterans Affairs, the views I am expressing today are my own and do not reflect official positions of the GGAC.

First, I would like to thank the Committee for its role in ensuring the passage of the Veterans Health Care, Capital Asset and Business Improvement Act of 2003, Public Law 108-170, Section 105. Prior to the passage of this Act, the Service Contract Act was often cited as a burden and a reason for not contracting with the VA. Under this new law, providers that serve Veterans can now enter into "agreements" with the VA, and will no longer be subject to the detailed reporting requirements of the Service Contract Act. Without access to community providers, the VA would be unable to meet its objectives of providing a continuum of long term care. Thus the availability of these agreements will help to ensure that needed long term care services will be more readily available to Veterans in the communities where they live.

As a member of the Federal Advisory Committee on the Future of VA Long Term Care, I have strongly supported the need for policies that will shift the VA's approach to geriatrics and extended care from one that is institution focused to one that is patient-centered, and offers home and community based options. I believe the VA's policies should offer care to Veterans in their homes for as long as possible, and provide viable options in addition to nursing home placement. Indeed, the Centers for Medicare and

Medicaid Services and Medicaid Programs across the country have achieved a dramatic reduction in spending on institutional care through the funding of home and community based "waiver" programs as well as other innovative programs, such as Programs of All Inclusive Care for the Elderly (PACE), an integrated service delivery model that utilizes an adult day health center as the hub of care.

One of the central recommendations of the Federal Advisory Committee was to make home and community based care options the preferred placement when clinically appropriate. As a target, the Committee sought to double the proportion of VA long term care spending from about 18 percent (in 1997) to 35 percent by 2010 (the planning horizon). The following snapshot illustrates the current mix of services and reveals that the VA has not yet achieved this target:

- The VA spent $3.262 billion on long term care programs in FY 2002, with 91% of spending on institutional care and 9% of spending on non institutional care (GAO-03-487, May 2003).

- By comparison, Medicaid spent $75.288 billion on long term care in 2001, with 71% of spending on nursing homes and ICF/MR and 29% of spending on home and community based care (GAO-03-576, June 2003).

While the comparison with Medicaid program spending shifts is not entirely comparable because of the differences in the benefits and populations served, it does illustrate the responsiveness of the Medicaid programs to meet the desires of the elderly in a cost effective manner.

I would also like to draw your attention to the growth of assisted living in the private sector. Over the past decade, assisted living has emerged as a long term care alternative for seniors who need more assistance than is available in independent living, but who do not require the heavy medical and nursing care provided in nursing homes. Assisted living facilities are designed to be operated, staffed and maintained to meet the needs and

desires of its residents. Between 1995 and 2000, the National Academy of State Health Policy (NASHP) reports that the number of assisted living facilities has doubled from about 16,000 facilities to about 33,000 facilities with almost 800,000 beds nationwide. While most assisted living services are paid for privately, Medicaid funding for assisted living is growing. The NASHP reports that 41 states serve 102,000 residents in assisted living or residential care settings. During this same time, the number of nursing home beds has remained approximately flat at approximately 1.8 million beds, and median occupancy has declined to 82 percent. The assisted living sector of the long term care industry has been growing, with assisted living substituting for some nursing home services.

Veterans, however, have limited access to assisted living services through the VA. At present, the VA provides assisted living services on a pilot basis in one VISN, but anticipates the start-up of eight assisted living developments through the enhanced use lease program. However, Veterans residing in non VA operated assisted living facilities in the community can access VA long term care services, such as home based primary care.

The VA has made progress in developing a wider array of home and community based programs, including respite care, home based primary care, geriatric evaluation, adult day health care, homemaker/home health aide programs and skilled home health care. The VA has also introduced a performance measure to encourage the networks to provide these long term care services at the local level. Nevertheless, it is clear that additional progress needs to be made in ensuring greater availability of these programs across VISNs.

The Medicaid statistics that I have highlighted illustrate how policies can successfully impact shifts in the utilization of services. Medicaid has achieved much of this shift in spending from institutional care to home and community based care through comprehensive “waiver” programs that target beneficiaries who meet nursing home admission requirements. However, I believe that it is difficult if not impossible for the

VA to achieve a shift of this magnitude within the current policy constraints. Therefore, I offer the following recommendations for discussion about how the VA can achieve its goals of "rebalancing" the institutional and non institutional long term care delivery system.

1. Currently, the VA has a requirement that the nursing home services provided in VA facilities are no less than the level provided in the 1998 base year. This requirement is particularly stringent because it does not take into account nursing home care provided in state homes and contract community nursing homes. This requirement forces the VA to continue its emphasis on nursing home care rather than shift its emphasis to home and community based care services. **Instead, I recommend that the VA be given the flexibility of providing the most appropriate total long term care services that are clinically appropriate. In order to maintain accountability for the provision of long term care services, the VA could be required to maintain a specified level of long term care funding as a baseline, but then have the flexibility to shift that funding towards home and community based services when clinically appropriate. Performance measures should also be applied to ensure that quantity and quality of services are satisfactory.**

2. As authorized by the Veterans Millennium Healthcare and Benefits Act (PL 106-117), has initiated PACE pilots in 3 sites, each implementing a variation on the PACE model. The Denver, Colorado site uses the VAMC as its partner. The Columbia, South Carolina site utilizes VAMC oversight of the community PACE provider. Finally, the Dayton, Ohio site utilizes the VA as the sole provider of PACE services rather than a community PACE provider. I have attached a description of the VA PACE Program operated with Palmetto Senior Care in Columbia, South Carolina, which illustrates the comprehensive services that are provided and coordinated through the Program.

In the first year of operation, the three sites enrolled a total of 222 veterans with an average age of 75. An interim evaluation of the first year of operation has shown that Veterans and their caregivers are highly satisfied with the program, and reduced rates of nursing home and hospital use have occurred. The final evaluation of the PACE pilot is due to Congress in early 2005. Unfortunately, funding for the pilot is expected to terminate as of July 2004, prior to the completion of the evaluation. Should the pilot projects be terminated, these VA specific PACE programs will be dismantled before they can serve as models for other VISNs.

By the time that the VA began its pilot program, the PACE program had already moved from demonstration status to provider status for the Medicare and Medicaid programs over a 20 year period. The Balanced Budget Act of 1997 Congress recognized the success of the demonstration and PACE became a permanent provider. At present, 31 Medicare and Medicaid certified programs serve almost 10,000 participants on a daily basis. Independent evaluations of the PACE program by the Centers for Medicare and Medicaid Services (CMS) have found the PACE programs to offer high quality, cost effective care that is desired by seniors and their families. With this track record of success, CMS is actively encouraging states to develop and expand PACE programs as a cost-effective alternative to nursing home placement.

Given the CMS experience with PACE over two decades, it is highly likely that the PACE program will also meet the needs of Veterans. **Therefore, I recommend the following:**

- **Congress should authorize the VA to continue funding and continue new enrollment in the existing PACE pilot programs until the evaluations are complete and an informed decision can be made about whether to make these programs a permanent part of the VA long term care continuum.**

- **Should the final evaluation be positive, the VA should expand access to PACE programs where viable using the most appropriate model. In some rural communities, PACE programs can be developed in partnership with other agencies, such as the Indian Health Service.**

3. Similarly, the Millennium Healthcare and Benefits Act also authorized one Assisted Living Pilot. This pilot has operated in VISN 20 (Washington, Alaska, Oregon and Idaho). The evaluation of the assisted living pilot is due to Congress in late 2004, with funding for the pilot expected to terminate before the evaluation is complete. Anecdotal reports indicate that the assisted living pilot is serving Veterans with more chronic impairments in daily living than those who are currently served at the domiciliary level of care, and thus providing a level of support that is not now available within the VA long term care continuum. **Again, I recommend that Congress authorize the VA to continue funding the Assisted Living Pilot until the evaluation is complete and an informed decision can be made about whether or not to continue and/or expand this program to other VISNs.**

4. The State Home Program has been highly successful in meeting the long term care needs of Veterans. Currently, the state home construction program and the per diem program provide construction funding and on-going funding through the VA for nursing home level of care, domicillary care and now adult day health care (in planning). While the State Home Program continues to meet the needs of aging Veterans for nursing home care and domiciliary care, it does not fund the construction or operation of assisting living facilities, a level of care that should be more available to Veterans. **Therefore, consideration should be given to utilizing the VA State Home Construction Grant Program and Per Diem Program to spur development of assisted living facilities, with a higher priority given to assisted living projects.**

Finally, I would like to note the accomplishments of the VA's Geriatric Research, Education and Clinical Center Program. There are now 21 GRECCs nationwide that are translating their research into programs that improve the lives of older Veterans. In several research projects, including the evaluation of Geriatric Evaluation and Management Units and the development of the Resident Assessment Instrument, GRECCs have developed tools and models of care that have been adopted by the broader aging community. We look forward to the continued success of GRECCs towards the benefit of Veterans and all seniors.

In conclusion, I hope that these recommendations will spur discussion among Congress, Veterans and the VA about how to best utilize the limited resources available to meet the long term care needs of aging Veterans. Thank you again Chairman Smith and members of the Committee for the opportunity to present my views about how to provide Veterans with access to the entire continuum of long term care programs and services.

Brief Bio for
Jade Gong, R.N., M.B.A.
Member, Geriatrics and Gerontology Advisory Committee
To the Secretary of Veterans Affairs

Jade Gong has 20 years of experience in health care strategy, policy and reimbursement, with expertise in Medicare, Medicaid and VA long term care issues. She has served as a Secretarial Appointee to the Geriatrics and Gerontology Advisory Committee since 1995. In 1998, she was also a Secretarial Appointee on the Federal Advisory Committee on the Future of VA Long Term Care. In 1999, she served on the selection committee for the VA Assisted Living Pilot.

As the Principal of Health Strategy Associates, Ms. Gong advises national associations and health care providers on the need for both institutional and community based long term care programs for seniors, including State Veterans Homes. She is currently assisting several non-profit health care organizations to develop an innovative home based program for the elderly known as the Program of All Inclusive Care for the Elderly (PACE).

From 1989-1994, Ms. Gong was the Director of Reimbursement and Finance for the American Health Care Association, the national association representing long term care and assisted living providers. Prior to that time, she was Project Manager at Lewin and Associates (now the Lewin Group, a national health care consulting firm) where her clients included HCFA's Office of Research and Demonstration, State Medicaid Agencies and health care providers.

Ms. Gong has a MBA from Yale University and a BS in Nursing, cum laude, from New York University.

Disclosure: I have received no compensation from the VA in 2002 and 2003.