Long-Term Care Services for Veterans

‚name redacted,
Specialist in Health and Aging Policy

‚name redacted,
Specialist in Veterans Policy

November 28, 2016

Congressional Research Service
7-....
www.crs.gov
R44697

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Veterans Health Administration (VHA), an operating unit of the Department of Veterans Affairs (VA), is a direct service provider of health care, similar in many ways to a large private sector health care system. In addition to providing inpatient, outpatient, and a range of other medical care services, the VHA provides and purchases long-term care services. The VA is one of two federal payers of long-term care services (the other being Medicaid).

Since the 1960s, the VA has been authorized to provide nursing home care to eligible veterans in various settings, including VA facilities, private nursing facilities contracted by the VA, and state veterans homes (P.L. 88-450). These nursing home benefits were further expanded in subsequent legislation (P.L. 91-101 and P.L. 93-82). In 1999, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) required the VA to provide such benefits to veterans needing nursing home care due to one of their service-connected conditions, as well as veterans who overall have a service-connected disability rating of 70% or more, who need the care for any condition, service-connected or not. In addition, the law required the VA to maintain staffing and level of services for institutional care not less than the FY1998 level; the law also required non-institutional long-term care services as part of the VA medical benefits package.

About 9.1 million veterans (43% of all veterans) were estimated to be enrolled in the VHA in FY2016. Although the overall number of veterans in the United States has declined since FY2000, the number of veterans enrolled in the VHA has increased significantly in that same time period. In FY2000, just over 4.9 million veterans were enrolled in the VHA; by FY2016 that number was estimated to have increased 86%, to 9.1 million enrollees. This increase is due, in part, to the growing number of veterans with service-connected disabilities, as well as more liberal enrollment policies. Among veterans with a service-connected disability, the proportion who have a disability rated as 70% or more service-connected (and therefore eligible for VA paid nursing home care) has also increased.

VA long-term care programs are administered at the VA facility level, with some variability in how programs are administered. Each VA facility offers certain mandatory programs and may offer several optional programs as well. Eligibility for VA long-term care programs depends on eligibility for VA health care, which is based primarily on "veteran status" resulting from military service. Once enrolled, veterans' eligibility for long-term care services depends on several factors, including veterans' need for the service (as determined by the VA), whether the service is institutional or non-institutional, and (for certain programs), veterans' service-connected status.

Institutional settings may include both inpatient acute care and nursing home care. However, the majority of VA long-term care provided in institutional settings occurs in nursing home facilities, such as VA Community Living Centers (CLCs), community nursing homes, and state veterans homes. Non-institutional care includes outpatient and ambulatory care settings, as well as care that occurs in the home or another community-based setting. Non-institutional services include

- home-based primary care,
- community residential care,
- geriatric evaluation,
- palliative care,
- adult day health care,
- homemaker/home health aide care,
- respite care,

- home skilled care,
- home hospice, and
- veteran-directed home and community-based services and medical foster homes (at some facilities).

Some long-term care services are provided directly by VA staff, whereas others are purchased from providers outside of the VA. Long-term care expenditures are a small but not insignificant part of the VHA total medical care budget, at just over one-tenth of the VHA's budget. In FY2015, the VHA spent $7.4 billion (13% of its total appropriated funding for medical care, which was $55.8 billion) for veterans' long-term care. Institutional care accounted for almost $5.3 billion, or 71% of VA's total long-term care spending, while non-institutional care accounted for $2.1 billion, or 29%. The majority of VHA institutional care spending (64%) was for VA Community Living Centers (CLCs), nursing facilities owned and operated by the VA.

This report provides an overview of VA long-term care services, including legislative highlights, eligibility, organizational structure, descriptions of services (both institutional and non-institutional care), and expenditures. The report also describes three key issues for Congress when considering the VA and its long-term care financing and delivery system:

1. Veterans' access to long-term care services.
2. Settings where services are provided and the appropriate balance between institutional and non-institutional care.
3. Veteran's health coverage options and federal coordination.

Contents

Figures

Tables

Appendixes

Contacts

Introduction

The United States has a long history of providing benefits to those who have served in the defense of the nation. What began as a disability compensation and pension program for veterans during the early years of the republic has grown into a comprehensive veteran benefits and services system. The federal responsibility of managing this system has been entrusted by Congress primarily to the Department of Veterans Affairs (VA). The VA carries out its veterans programs nationwide through the following three administrations and an appeals board:

- The **Veterans Health Administration (VHA)** is responsible for veteran health care programs.
- The **Veterans Benefits Administration (VBA)** is responsible for disability compensation, pension, vocational rehabilitation, education assistance, home loan guaranty, and insurance, among other benefits.
- The **National Cemetery Administration (NCA)** is responsible for providing burial space and maintaining national cemeteries, among other responsibilities.
- The **Board of Veterans Appeals (BVA)** renders final decisions on appeals regarding veteran benefits claims.

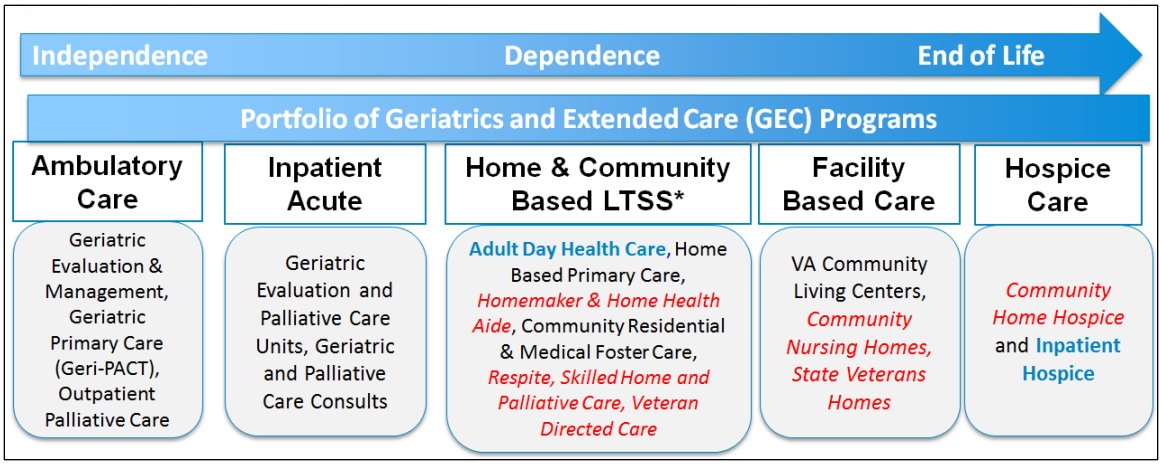
The VHA, the largest and most visible operating unit, is predominantly a direct service provider of primary and specialty care, similar in many ways to a large private sector health care system. However, some aspects of the VHA are very different from a private health care system. Not only does the VHA employ health professionals to provide health care services directly, but the VHA also purchases care for certain veterans from community health providers. Further, the VHA provides social services and other supportive services—such as housing assistance, home health aide services, and adult day health care—that are rarely tied to private sector health care providers or financed by private health insurance or Medicare. Beyond the provision of health care and other support services to veterans and eligible family members, the VHA is statutorily required to conduct medical research into the special health care needs of veterans, to train health care professionals, to serve as a contingency back up to the Department of Defense (DOD) medical system during a national security emergency, and to provide support to the National Disaster Medical System and the Department of Health and Human Services (HHS) as necessary.[1]

In addition to providing inpatient, outpatient, and a range of other medical care services, the VHA has been authorized by Congress since the 1960s to provide nursing home care to eligible veterans in VA facilities, private nursing facilities contracted by the VA, and state veterans homes. Although the VHA initially provided only institutional-based long-term care, VA long-term care services have expanded to include a full range of long-term services and supports (LTSS)—both institutional and non-institutional. These services include programs of care directly provided by the VA, such as home-based primary care and geriatric evaluation, as well as services purchased by the VA, such as home health aide and home respite care. The VA typically refers to programs under this broad umbrella as Geriatrics and Extended Care (GEC) Programs[2] (see **Figure 1** and text box for terminology used in this report). These programs share a primary goal: to support veterans to remain safe in the least restrictive environment.

[1] 38 U.S.C. §§7301-7303; §8111A; §1785.

[2] The VHA also provides dementia care; transitional care; health care workforce development; Geriatric Research Education, and Clinical Centers (GRECCs); and Geriatrics and Extended Care (GEC) Field Programs and Resource Centers. However, a broader discussion of these programs and services is beyond the scope of this report.

Figure 1. Components of VHA Geriatrics and Extended Care Programs



Source: Veterans Health Administration, presentation at "Geriatrics and Extended Care: Next Steps Summit," August 4, 2016.

Notes: LTSS = Long-Term Services and Supports; black text = VA provided care; red text (italicized) = purchased community care; blue text (bold) = both VA and purchased community care. In addition, the VHA provides dementia care; transitional care; health care workforce development; Geriatric Research Education, and Clinical Centers (GRECCs); and GEC Field Programs and Resource Centers.

This report provides an overview of the long-term care services offered by the VA, whether directly provided or purchased from the community. It first provides a brief history of legislation relevant to VA long-term care services. Next, it provides information on veteran eligibility for care and enrollment, to give a picture of who these programs serve. It then provides an overview of the structure of the VHA to explain how care is administered, followed by a description of the various long-term care programs that the VA offers. Finally, the report discusses potential issues of interest for Congress.

Terminology Used in This Report

Activities of Daily Living (ADLs) are tasks of personal care, such as bathing, dressing, toileting, transferring, and feeding oneself.

Geriatrics and Extended Care (GEC) programs are typically accessed by veterans aged 65 and older and veterans with disabilities. GEC encompasses both LTSS and other services, including ambulatory and inpatient acute care, as well as hospice services not typically associated with LTSS. In this report, the broad term "long-term care," or LTC, is primarily used when referring to GEC programs.

Instrumental Activities of Daily Living (IADLs) are household tasks such as housekeeping, meal preparation, laundry, grocery shopping, transportation, and managing finances.

Permanently and Totally Disabled means, as adjudicated by the VA, the service-connected disability rating is total (any impairment of mind or body sufficient to render it impossible for the average person to follow a substantially gainful occupation) for the purposes of VA disability compensation and where the impairment is reasonably certain to continue throughout the life of the disabled veteran (38 U.S. Code §1502; 38 C.F.R. §3.340).

Long-Term Care (LTC) generally refers to care that individuals may need over their lifespan to assist with personal care needs. LTC may be delivered in institutional or community/home-based settings.

Long-Term Services and Supports (LTSS) is sometimes used interchangeably with long-term care. LTSS refers to a broad array of both institutional and home and community-based services and supports designed to help people with their personal care needs and ability to maintain independence.

Service-Connected Disability means, with respect to disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service (38 U.S.C.§101(16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

U.S. Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) are used throughout this report; VA and VHA are used interchangeably to primarily refer to the Veterans Health Administration.

Brief Legislative History

1960s-1970s

Prior to the enactment of P.L. 88-450 in 1964,[3] the VA did not have explicit statutory authority to provide nursing home care to veterans in VA facilities; however, the VA did provide a limited form of institutional care in its domiciliaries for those who no longer needed hospitalization.[4] Toward the end of FY1964, within the scope of existing statutory authority,[5] the VA began making plans to implement a nursing home care program with 2,000 beds in VA hospitals "for those veterans who have obtained maximum hospital benefits, [but] are too physically disabled for domiciliary care, and still have a need for nursing care which for various reasons cannot be provided in the community."[6] In August 1964, P.L. 88-450 authorized, among other things, 4,000 beds for nursing home care. It further authorized care in private or public nursing homes for no more than six months at VA expense for VA patients who had received maximum hospital benefits but who still needed long-term nursing home care. If the veteran needed permanent nursing home care for more than six months, the veteran would be placed in a VA nursing home rather than a private nursing home.[7] P.L. 88-450 also authorized the VA to make per diem payments to state veterans' nursing homes for the care of eligible veterans. In enacting P.L.88-450, Congress recognized the growing need for nursing home care for World War II veterans in future years, and at the same time recognized the need for VA to move patients from expensive hospitals settings (when they no longer needed hospitalization) to less expensive nursing home settings for longer-term convalescence.[8]

P.L. 91-101, enacted in 1969,[9] amended P.L. 88-450 and eliminated the six-month limitation on care at a contracted community nursing home for veterans who were previously hospitalized in a

[3] An Act to amend title 38, United States Code, to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, and for other purposes.

[4] See U.S. Congress, House Committee on Veterans Affairs, *Nursing Home Care For Veterans*, report to accompany H.R. 8009, 88th Cong., 1st sess., August 14, 1963, H.Rept.88-680, p. 27. The domiciliary care program evolved from the National Homes for Disabled Volunteer Soldiers established by Congress in 1866. Today, the domiciliary care program has been integrated into Mental Health Residential Rehabilitation and Treatment Programs (MH RRTPs) (http://www.va.gov/homeless/dchv.asp). Further discussion and analysis of the domiciliary care programs is beyond the scope of this report.

[5] See Veterans Administration General Counsel opinion dated May 7, 1963, titled "Legal Authority to Provide Nursing Home Type Care" included in U.S. Congress, House Committee on Veterans Affairs, *Nursing Home Care For Veterans*, report to accompany H.R. 8009, 88th Cong., 1st sess., August 14, 1963, H.Rept.88-680, p. 26.

[6] U.S. Congress, House, *Annual Report of the Administrator of Veterans Affairs, FY1964*, 89th Cong., 1st sess., H.Doc.89-8, p. 28.

[7] See U.S. Congress, House Committee on Veterans Affairs, *Nursing Home Care For Veterans*, report to accompany H.R. 8009, 88th Cong., 1st sess., August 14, 1963, H.Rept.88-680, p. 8, and U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans*, committee print, prepared by National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, H. Committee Prt. 36 (Washington: GPO, 1977), p. 212.

[8] Ibid.

[9] An Act to amend title 38 of the United States Code in order to eliminate the six month limitation on the furnishing of nursing home care in the case of veterans with service-connected disabilities.

VA hospital for a service-connected disability. For all other veterans, the six-month limitation applied, but the VA was authorized to extend the time period at its discretion. The Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further liberalized eligibility for contracted community nursing home care for veterans with service-connected conditions and authorized the VA to provide nursing home care to veterans in contracted community nursing homes without having to be admitted to a VA hospital first.

1980s-1990s

In 1998, a Federal Advisory Committee on the Future of VA Long-Term Care found that

> VA's long-term care system developed incrementally in the 1970s and early 1980s. Nursing home care remains its primary emphasis, while home and community based care is underdeveloped. In addition, long-term care programs are not fully integrated into the healthcare system at many VA facilities. Despite a continuum of offerings, services are not available universally and access often is restricted. Many facilities do not have mechanisms for coordinating long-term care services, relying on episodic admissions to individual programs. Long-term care is largely viewed as an adjunct rather than an integral part of the healthcare system, VA long-term care services must be remodeled to effectively deliver needed services.[10]

Based on recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care, Congress began to examine the VA's long-term care programs, which led to the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) in November 1999. This act, among other things, mandated nursing home care for veterans with a service-connected condition in need of such care and for veterans with nonservice-connected conditions who are 70% or more service-connected disabled. Among other things, it also required the VA to provide non-institutional care, such as home-based care and adult day health care, to all enrolled veterans. In his signing statement, President Clinton stated:

> This bill is especially significant for its approach in the provision of enhanced extended care services to veterans. It firmly establishes that the Department of Veterans Affairs (VA) should accord the highest priority for nursing home care to the most severely disabled veterans and those needing care for service-connected disabilities. It will also ensure that veterans enrolled in the VA health care system receive noninstitutional, extended-care services, including geriatric evaluations and adult day health care.[11]

VHA Eligibility, Enrollment, and Long-Term Care

In general, eligibility for VA long-term care services depends on several factors, including veterans' need for the service, as determined by the VA; whether the service is institutional or non-institutional; and, for certain programs, veterans' service-connected status. However, to understand eligibility for VA long-term care services, it is important to understand eligibility for VA health care in general, the VA's enrollment process, and its enrollment priority groups. Unlike Medicare or Medicaid, VA medical care is not an entitlement program. Contrary to numerous

[10] Federal Advisory Committee on the Future of VA Long-Term Care, *VA Long-Term Care at the Crossroads*, Washington, DC, June 1998, p. 2.

[11] U.S. President (Clinton, W.J.), "Statement on Signing the Veterans Millennium Health Care and Benefits Act," *Compilation of Presidential Documents: Administration of William J. Clinton, 1999* (Washington: GPO, 1999), p. 2473.

claims made concerning promises of "free health care for life," not every veteran is automatically entitled to health care from the VA.

Overview of VHA Eligibility

Eligibility for VA health care is based primarily on "veteran status" resulting from military service. In general, veteran status is established by active-duty status in the military, naval, or air service and a discharge or release from active military service under "other than dishonorable" conditions (e.g., general, honorable, under honorable conditions). After veteran status has been established, the VA next places an applicant into one of two categories.[12]

The first category comprises veterans with service-connected disabilities or with incomes below an established threshold. Service-connected disability means that such disability was incurred or aggravated in the line of duty in active service. Veterans with service-connected disability or income below the threshold are regarded by the VA as "high priority" veterans and are enrolled in Priority Groups 1-6 (see **Figure B-1**). The second category of veterans comprises those who do not fall into one of the first six priority groups—primarily veterans with nonservice-connected medical conditions and with incomes above the VA-established threshold. These veterans are enrolled in Priority Group 7 or 8.[13]

As shown in **Table 1**, the majority of VA-enrolled veterans (77%) fall into Priority Groups 1-6, with 23% of veterans in Priority Group 1 (those with 50% or more service-connected disability or determined by VA to be unemployable due to service-connected conditions) and 22% of veterans in Priority Group 5 (those with incomes below the threshold, receiving VA pensions, or receiving Medicaid). Once veterans are enrolled in the VA health care system, they remain in the system and do not have to reapply for enrollment annually, unless they wish to disenroll formally.

Table 1. VHA Unique Enrollees, by Priority Group, FY2015

Priority Groups	Number of Veterans	Percentage of Veterans
1	2,067,424	23%
2	740,516	8%
3	1,245,423	14%
4	236,560	3%
5	2,015,204	22%
6	562,595	6%
Subtotal Priority Groups 1-6	**6,867,722**	**77%**
7	387,345	4%
8	1,710,856	19%
Subtotal Priority Groups 7-8	**2,098,201**	**23%**
Total Enrollees	**8,965,923**	**100%**

[12] For more information, see CRS Report R42324, *Who Is a "Veteran"?—Basic Eligibility for Veterans' Benefits.*

[13] For further information, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

Source: Table prepared by the Congressional Research Services based on Department of Veterans Affairs, *FY2017 Budget Submission, Medical Programs and Information Technology Programs*, Volume II, February 2016, p. VHA-24.

Note: Unique enrollees represent the count of Veterans enrolled for veterans health care sometime during the course of the year; for a description of Priority Groups, see **Figure B-1**.

VHA Enrollment

The size and scope of the VA health care system are influenced by several factors, including the size of the veteran population, the number of veterans eligible for VA health care, veterans' decisions about whether to enroll, and once enrolled, whether to utilize VA health care services, including long-term care services. An estimated 9.1 million veterans (43% of all veterans) were enrolled in the VA health care system in FY2016.[14] Those not enrolled are either ineligible to enroll or eligible but choose not to enroll. In addition, some veterans may be eligible but unaware of their eligibility status. While overall the number of veterans in the United States has declined since FY2000, the number of veterans enrolled in the VA health care system has increased significantly.

The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The VHA began formally enrolling veterans for the first time in FY1999. As shown in **Figure 2**, just over 4.9 million veterans (19% of all veterans) were enrolled in the VHA in FY2000; by FY2016, that number was estimated to have increased 86%, to 9.1 million enrollees.[15] This increase is due, in part, to factors such as enrollment in newer veterans from Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), a larger number of female veterans, and economic conditions, among other factors.[16] The number of veterans receiving VA health care services is projected to level off over the next 10 years.[17]

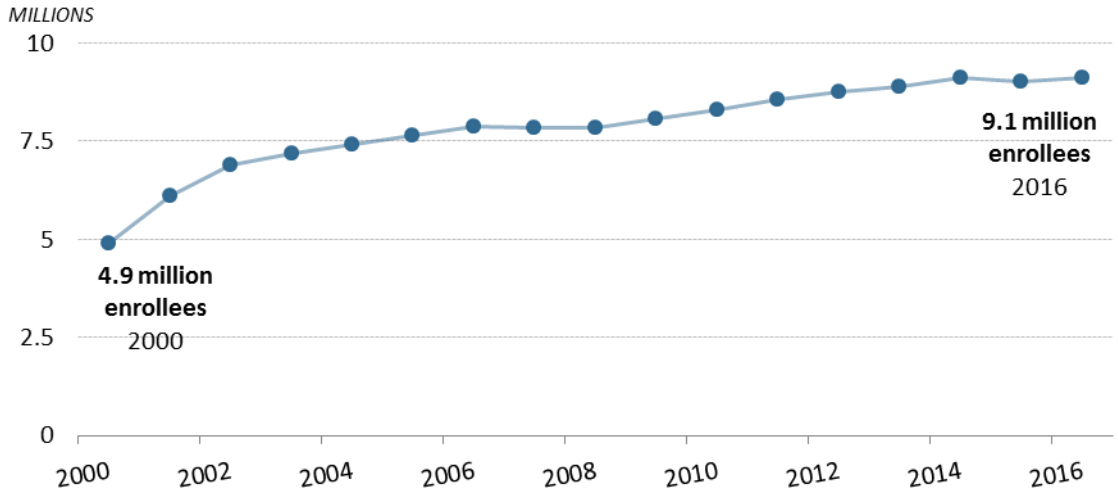
[14] Department of Veterans Affairs, *FY2017 Budget Submission, Medical Programs and Information Technology Programs*, Volume II, February 2016, p. VHA-24; National Center for Veterans Analysis and Statistics, Veteran Population. Population Tables, https://www.va.gov/vetdata/Veteran_Population.asp.

[15] Ibid.; Richardson, C. and J. Waldrop, *Veterans: 2000, Census 2000 Brief*, U.S. Census Bureau, May 2003, http://www.census.gov/prod/2003pubs/c2kbr-22.pdf.

[16] Department of Veterans Affairs, *FY2017 Budget Submission, Medical Programs and Information Technology Programs*, Volume II, February 2016, p. VHA-180.

[17] RAND Corporation, Assessment A (Demographics), product of the CMS Alliance to Modernize Healthcare, Centers for Medicaid & Medicare Services (CMS), prepared for the U.S. Department of Veterans Affairs, September 1, 2015, pp. xii-xiii.

Figure 2. VHA Enrolled Veterans, FY2000 to FY2016



Source: VA-Enrolled Veterans numbers were obtained from the Department of Veterans Affairs (VA) and/or the VA budget submissions to Congress for FY2002-FY2016; the number for each fiscal year is taken from the budget submission two years later (e.g., the FY2000 number is from the FY2002 budget submission).

Note: FY2000 to FY2015 numbers are actual; the FY2016 number is an estimate.

Veterans and Long-Term Care

VHA enrollees are a clinically complex population with significant health care needs. VHA enrollees are more likely than nonveterans to be diagnosed with chronic health conditions, including those linked to their military service.[18] For example, conditions such as PTSD are more prevalent in veterans compared with nonveterans, as are conditions such as cancer and diabetes. This likelihood is due, in part, to VHA eligibility policies based on service-connected conditions. Moreover, VHA policies regarding mental health screening, for example, lead to higher rates of diagnosis. In addition, veterans who access the VHA also tend to be older, less socioeconomically well off, and less healthy than veterans who do not rely on the VA for care.[19]

The VA health care system faces the challenge of providing care to those aging with disability as well as those aging into disability. Veterans of all ages may need long-term care, both younger veterans with disabilities and aging veterans. Moreover, the number of veterans with a service-connected disability, defined as a disability caused by injury or disease incurred or aggravated during active military service, is increasing. The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% (in increments of 10%) based on the severity of the disability. As shown in **Figure 3**, nearly 2.5 million veterans had a service-connected disability in FY2003; by FY2013, that number had increased to over 3.7 million. Moreover, the number of veterans who are rated in the highest disability rating group (i.e., veterans with 70% to 100% service-connected disabilities) has increased. Among those veterans with service-connected conditions, about 2 in 10 veterans (18%) were rated as having 70% to 100% service-connected disabilities in FY2003, compared with 3 in

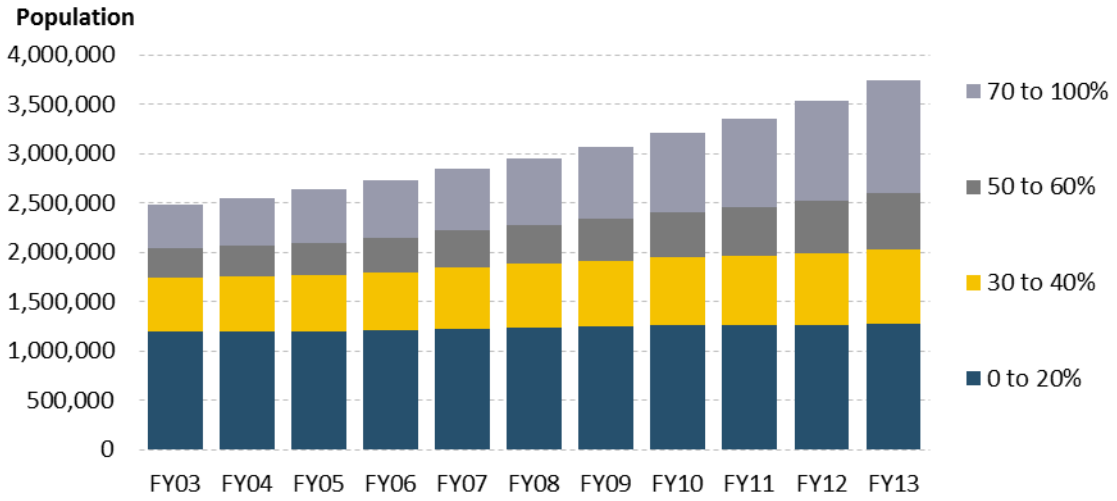
[18] RAND Corporation, Assessment A (Demographics), product of the CMS Alliance to Modernize Healthcare, Centers for Medicaid & Medicare Services (CMS), prepared for the U.S. Department of Veterans Affairs, September 1, 2015, pp. xv-xvii.

[19] Ibid., p. xii.

10 veterans (30%) in FY2013. As the number of veterans with a service-connected disability increases, the demand for VA long-term care services over a veteran's lifespan will likely increase.

Figure 3. Service-Connected Disabled Veterans, by Disability Rating Group

FY2003 to FY2013



Source: Department of Veterans Affairs, COIN CP-127 Reports; 2003-2013: Annual Benefits Reports, prepared by the National Center for Veterans Analysis and Statistics.

The need for long-term care typically increases with age. In the general population, it is estimated that about half (52%) of individuals turning age 65 will develop a disability serious enough to need long-term care. Most will need care for two years, on average. However, one in seven is expected to have care needs for five years or more.[20] Because the veteran population is older than the general population, long-term care services are an important part of VA's health benefits package. In 2016, 48% of all veterans enrolled in the VHA were aged 65 and over, compared with 15% of the general population (as of 2015).[21] The majority of older veterans (85%) are aged 65 to 84. Vietnam-era veterans are the largest cohort of veterans and the cohort now reaching advanced age.

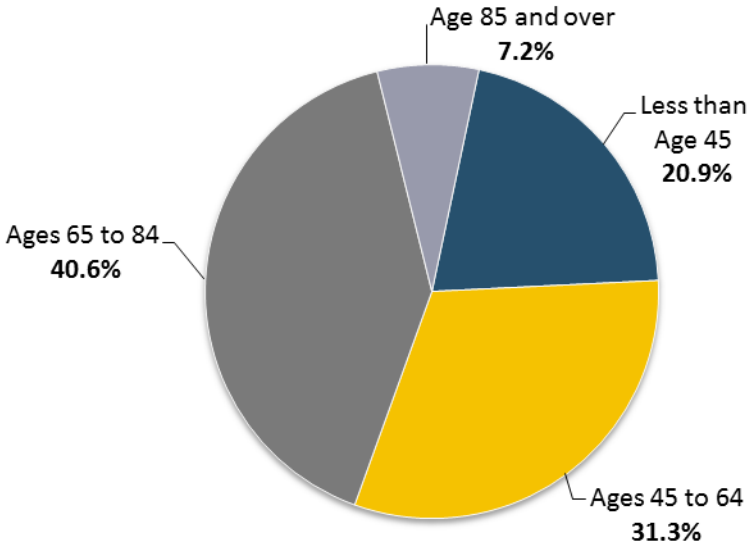
[20] U.S. Department of Health and Human Services, *Long-Term Services and Supports for Older Americans: Risks and Financing*, ASPE Issue Brief, February 2016.

[21] Data on veterans enrollment by age obtained through personal communication with VHA Office of Geriatrics and Extended Care Services, September 9, 2016; U.S. Census Bureau, QuickFacts United States, https://www.census.gov/quickfacts/table/AGE775215/00.

.

Figure 4. VHA Enrollment, by Age Group

FY2016 (Projected)



Source: CRS analysis based on data obtained by the Department of Veterans Affair; data are projected end of year enrollees by age group for FY2016.

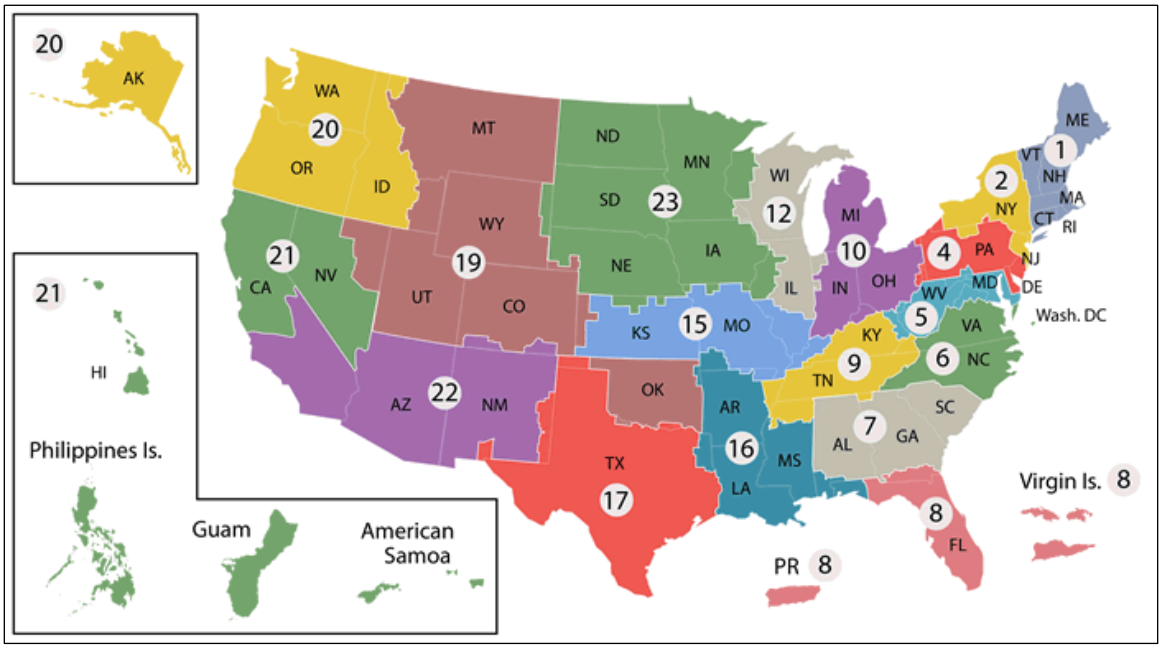
VHA Organization and Long-Term Care

Overview of VHA Organization

The VHA is the largest integrated health care system in the United States, with over 1,700 sites of care, including medical centers, nursing facilities, clinics, and vet centers.[22] To administer this large system, the VHA has divided the country into Veterans Integrated Service Networks (VISN), based on geography (see **Figure 5**). There are currently 18 VISNs, which vary regarding the number of sites of care, the types and number of facilities, and the geographic size of the network's region. Each VISN has a VISN Director, who has oversight of the VA facilities within that VISN and directly supervises the facility director at each facility.

[22] U.S. Department of Veterans Affairs, Locations, Veterans' Health Administration, accessed August 2, 2016, at http://www.va.gov/directory/guide/division.asp?dnum=1.

Figure 5. Veterans Integrated Service Networks (VISN)



Source: Veterans Health Administration, http://www.va.gov/directory/guide/division.asp?dnum=1.

Veterans Integrated Service Networks (VISN):

VISN 1: VA New England Healthcare System
VISN 2: VA Health Care Upstate New York
VISN 4: VA Healthcare - VISN 4
VISN 5: VA Capitol Health Care Network
VISN 6: VA Mid-Atlantic Health Care Network
VISN 7: VA Southeast Network
VISN 8: VA Sunshine Healthcare Network
VISN 9: VA MidSouth Healthcare Network
VISN 10: VA Healthcare System
VISN 12: VA Great Lakes Health Care System
VISN 15: VA Heartland Network
VISN 16: South Central VA Health Care Network
VISN 17: VA Heart of Texas Health Care Network
VISN 19: Rocky Mountain Network
VISN 20: Northwest Network
VISN 21: Sierra Pacific Network
VISN 22: Desert Pacific Healthcare Network
VISN 23: VA Midwest Health Care Network

Note: VA's VISN realignment, beginning FY2016 to FY2017 (anticipated), integrates the following: VISN 3 into VISN 2, most of VISN 11 into VISN 10, and VISN 18 into VISN 22; in January 2002, VISN 13 and VISN 14 merged to become VISN 23.

For example, VISN 10 has oversight of VA facilities in Indiana, the lower peninsula of Michigan, and Ohio, including 10 medical centers (VAMCs) and one outpatient health care center (HCC). Each of these main facilities has associated community based outpatient clinics (CBOCs) under its purview; for example,

- Cleveland, OH VAMC has 12 CBOCs in outlying areas, such as Akron and Canton.
- The Columbus, OH, HCC has four CBOCs, including Zanesville and Marion.

Many facilities also have a Community Living Center (CLC), which is a nursing facility owned and operated by the VA. The CLC may be located within the same physical structure as the VA hospital, or it may be a separate structure at a nearby location; regardless, the CLC is considered a part of the parent VAMC and is under the direction of that facility's director. Alternatively, VISN 1 covers more states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) and has 11 VAMCs. In contrast, VISN 21 covers a large geographical area and has nine VAMCs in three states (Northern California, Hawaii, and Nevada) and covers U.S. territories such as Guam, which has one CBOC and one Vet Center under the purview of the VAMC in Honolulu, HI. **Table 2** shows national numbers of different types of facilities as of December 2015.

Table 2. Selected VHA Facility Types and Number, 2015

Facility Type	Description	Number
Medical Centers (VAMC)	Generally VA hospitals, but any site of care including at least two of the following: inpatient, outpatient, residential, institutional extended care	167
Health Care Centers (also known as Ambulatory Care Centers) (HCC)	VA outpatient facilities that offer specialty and ambulatory surgery services	14
Community Living Centers (CLC)	VA nursing facilities, where veterans may receive care such as rehabilitation, custodial, and inpatient hospice care	135
Community Based Outpatient Clinics (CBOC)	Outpatient VA clinic that offers, at a minimum, primary and behavioral health care services and is associated with a parent VAMC or HCC	755
Vet Center	Community behavioral health counseling clinics	300

Source: Department of Veterans Affairs, *FY2017 Budget Submission, Medical Programs and Information Technology Programs, Volume II*, February 2016, p. VHA-153.

VA Long-Term Care Organization

VA LTC programs are administrated at the VAMC/HCC level. Each VAMC/HCC offers certain mandatory programs and may offer several optional programs as well. The VISN Director offers some oversight into programming, but each facility has latitude to administer the various programs, within the parameters of national handbooks and directives, resulting in variability from facility to facility even within the same VISN. For example, in VISN 17, which primarily encompasses the state of Texas, all but two of the VAMCs offer the Medical Foster Home Program (MFH). MFH is a VA-approved adult foster care setting and is not currently mandated nationally. The Waco and Harlington, TX, VAMCs do not offer MFH—a local facility decision that may be based on factors such as lack of patient demand, staffing, budget, and availability of interested caregivers. Another example of program variability is Veteran Directed Home and Community Based Services (VD-HCBS), a collaborative program of the VA and the Administration for Community Living (ACL) that provides veterans with a budget to direct their own home care services. As of June 2016, 61 VAMCs (out of 168) offered this program;[23] veterans served by other VA facilities do not have access to VD-HCBS. Nationally, the VHA Office of Geriatrics and Extended Care (GEC) provides guidance and oversight for these programs, including performance metrics, policy, auditing, and staff training.

At the facility level, LTC programs may be organized in one Geriatrics Department (often called a "Service" or "Care Line") or housed in one of several different departments (such as Social Work Service, Nursing Service, or Primary Care). Geriatrics Departments may be led by an Associate Chief of Staff for Geriatrics, or equivalent position, who is responsible at the facility level for the administration of LTC programs and reports to the facility chief of staff. From facility to facility, there is variability in program organization and management.

[23] For a complete list of VA facilities offering VD-HCBS, see the list at ACL Center for Integrated Programs website at http://www.acl.gov/Programs/CIP/OCASD/VDHCBS/index.aspx#Status.

VHA Long-Term Care Services

The VA offers long-term care in both institutional and non-institutional settings. Institutional settings may include both inpatient acute care and nursing home care, although the majority of long-term care the VA provides in institutional settings occurs in a nursing home setting, which is the primary focus in this report. Non-institutional care includes outpatient or ambulatory care settings, as well as care that occurs in the home or another community-based setting. These services cover a full spectrum of care needs, spanning veterans who are largely independent, to those who require significant assistance with basic daily activities, to those who are near the end of life. Some long-term care services are provided directly by VA staff, while other services are purchased from providers outside the VA. The subsection below describes non-institutional services provided and purchased by the VA. The next subsection provides information about long-term care provided in institutional settings.

Non-Institutional Care

The VA provides home and community-based care to eligible veterans enrolled in the VHA who meet certain clinical criteria (see **Table 3**). A primary goal of these programs is to support veterans in remaining safely in their home settings, with optimum health and wellness as they age. The VA is statutorily required to provide two non-institutional long-term care services: adult health care and respite care.[24] VA's other non-institutional long-term care services are provided as part of the health care benefits package.[25] Although the VA provides many of these services directly, it also purchases certain services from community providers and then pays those providers, similar to other federal payers such as Medicare. These programs are described below.[26]

VA Provided Care

The **Home Based Primary Care (HBPC)** program provides long-term, comprehensive primary care services to eligible veterans. Such services are coordinated by an interdisciplinary team that makes home visits. Generally, veterans who have difficulty getting around outside the home due to a chronic health condition or other long-term care need are eligible for HBPC. The HBPC team comprises VA staff, including physicians, nurse practitioners or physician's assistants, nurses, social workers, dietitians, physical or occupational therapists, psychologists, and pharmacists. Team members make separate home visits, form a medical care plan, and provide comprehensive case management for veterans. Primary goals of the program include maintaining veterans safely in their home, reducing hospitalizations and emergency department visits, and managing complex chronic illnesses to help increase veterans' quality of life. HBPC programs are accredited by the Joint Commission on the Accreditation of Health Care Organizations (Joint Commission) under home care standards and are surveyed every three years by the Joint Commission.

[24] 38 U.S.C. §1710B(a)(4) and §1710B(a)(6).

[25] 38 C.F.R. §17.38.

[26] In addition to the non-institutional programs described in this section, some VA facilities may offer certain unique non-institutional programs, which may have originated as special projects or as a result of designated program innovation funding from VA's central office. Typically these programs exist at one or more VA facilities but have not been adopted by all VA facilities. This report focuses on the mandatory programs, along with others that are not statutorily required or part of the health care benefits package, but that are more widely adopted across the VA.

The **Community Residential Care (CRC)** program is a supported housing program where veterans reside in a VA-approved group home. VA staff provide case management services to the veteran and monitor the care provided by the group home staff. The CRC program is designed for veterans who do not need a nursing home level of care, but do need support with their daily living skills, such as household tasks, meal preparation, and transportation. The veteran pays the CRC home out-of-pocket for room and board, which varies depending on geographic cost of living and amount of care provided. The VA staff make regular visits to see the veteran and inspect the home initially and annually. In addition, VA staff offer ongoing education and training to the CRC caregivers on topics such as infection control, working with challenging behaviors, and falls prevention.

For veterans who need more assistance than a CRC home can provide, the **Medical Foster Home (MFH)** program may be an option available at some VAs. MFH is a subset of the CRC program providing a higher level of care to eligible veterans. The veteran resides in a VA-approved adult foster care setting, with caregivers providing supervision 24 hour per day. Caregivers are private individuals, many of whom have nursing or nursing aide backgrounds, who choose to open up their home to veterans. The caregiver must also live in the home and may accept no more than three veterans as residents at a time. The MFH program is designed for veterans who would need nursing home level of care if not for significant in-home supports. The MFH caregiver provides assistance with personal care, supervision, and management of household tasks for the veteran. The veteran pays the MFH caregiver out-of-pocket for room and board, with these costs varying by the amount of care needed and geographic cost of living. All MFH veterans are also enrolled in a home visiting VA program, such as HBPC, which provides case management and oversight of the veteran's care. In addition, the VA MFH Coordinator arranges the placement of the veteran, monitors the care, organizes education and training for the caregivers similar to the CRC trainings, and arranges for initial and annual inspections of the homes that are conducted by VA staff, which typically includes the coordinator, a life safety expert, dietitian, and nurse.

In addition to programs offered in the home setting, the VA offers several outpatient clinic-based programs. The **Geriatric Evaluation** program, for example, is available at all VAs. The key component of geriatric evaluation is a comprehensive, interdisciplinary assessment, with team members typically including at least three disciplines, such as a physician, nurse, social worker, occupational or physical therapist, dietitian, and pharmacist. Veterans are referred from primary care or other specialties seeking input related to issues such as:

- increasing functional deficits;
- behavioral issues related to dementia;
- complicated psychosocial situations related to aging;
- polypharmacy (i.e., aging veterans who are taking medications that may cause side effects, and who could benefit from a simplified medication regimen); and
- frequent hospitalizations.

The team forms a recommended treatment plan and then either manages the implementation of that plan or makes recommendations back to the primary care team for how to best manage the veteran's care.

Another clinic-based option available to veterans is outpatient palliative care. The outpatient **Palliative Care Clinic** focuses on comfort care and symptom management for veterans with chronic illnesses helping to increase veterans' quality of life. Veterans may be seen in a Palliative Care Clinic even while continuing to receive curative treatment. Generally, veterans may have a prognosis of two years or less to live. Palliative care may also be appropriate earlier, when a

veteran's goals are primarily related to symptom management and quality of life. The Palliative Care Team includes a medical provider, social worker, nurse, chaplain, and may include a psychologist and dietitian. Hospice, a specific form of palliative care for veterans with six months or less to live, is provided in home or inpatient settings.

A limited number of VA facilities offer onsite **Adult Day Health Care (ADHC)**. ADHC is an outpatient day program that provides activities, socialization, supervision, and meals in a congregant setting. This program is targeted toward veterans who would need nursing home care if not for such assistance, including veterans who need assistance with personal care and daily living skills, as well as veterans with cognitive impairments that need supervision. ADHC programs generally offer structured activities such as restorative exercises and social activities (e.g., music, crafts, and outings), personal care, medication management, and meals.

VA-Purchased Care

Adult Day Health Care, as described above, is also purchased by the VA from community agencies. In this situation, the VA has agreements with local community agencies that provide ADHC services. The VA refers veterans to those ADHC sites, authorizes how many days per week the veteran may attend based on clinical need, and monitors the care provided via onsite visits made by VA clinical staff at least quarterly. In addition, the VA staff conducts an annual inspection of the ADHC site. The VA pays an agreed-upon daily or hourly rate to the ADHC sites, similar to state Medicaid programs.

Homemaker/Home Health Aide (H/HHA) services are another service that the VA purchases from community agencies. Clinical eligibility for H/HHA services is the same as for the ADHC program; veterans who are clinically eligible for nursing home level of care may receive home health aide services in their home, with the goal of keeping the veterans in their home rather than in a nursing facility. A VA provider assesses the need for care and places an order. Next, a VA coordinator contacts the veteran to discuss his or her needs, determines amount of care to be provided based on clinical need, and makes a referral to a community home health agency. The VA reassesses the veteran's need for care at least annually and assesses the agency's quality annually.

Respite services are also purchased by the VA and provided either in the home by a home health agency or in an ADHC setting. Respite services are intended to be short term and are generally limited to thirty days per calendar year per veteran; respite is meant to give the family caregiver a break from caring for the veteran. Clinical eligibility is the same as for ADHC or home health aide services.

The VA also purchases **skilled home care**, which is provided by qualified personnel for a limited time with the goal of rehabilitation or restoring health status. Skilled home care includes but is not limited to home physical, occupational, or speech therapy; wound care; and intravenous (IV) care. A VA physician determines that a veteran needs the skilled care and then orders the skilled care and VA coordinators contact the veteran and arrange the care. In general, the VA purchases skilled home care from Medicare-certified home care agencies. The VA monitors the agencies' quality measures at least annually.

Another service that the VA purchases from community agencies is **home hospice**. As mentioned previously, hospice is a type of palliative care or comfort care. To be eligible for hospice, a veteran must have a life-limiting diagnosis and a physician must determine that a veteran has a life expectancy of six months or less. The VA hospice coordinator then contacts the veteran and family to provide further education regarding hospice and makes a referral to a community hospice agency. The hospice agency provides an interdisciplinary care team, which manages the

symptoms of the life-limiting diagnosis, works with the veteran on goals for care, and seeks to improve quality of life. The team generally consists of a physician, nurses, a social worker, aides, and a chaplain. If the veteran's needs cannot be met in the home, the VA may pay for a general inpatient hospice stay or an inpatient respite stay in a community facility. Or the VA may transfer the veteran to a VA Community Living Center (CLC) to receive inpatient hospice services in a VA facility.

Finally, a limited number of VA facilities offer **Veteran-Directed Home and Community-Based Services (VD-HCBS)**. Clinical eligibility is the same as for ADHC or H/HHA services (see **Table 3**). VD-HCBS provides veterans with a budget for services, and the veteran determines how to use that budget to hire home health aides or arrange other supportive services to help the veteran live independently. The goals of the program are to provide the veteran more control and choices related to his or her care and to keep the veteran safely in his or her home. The veteran may use the funds to pay a family member or private citizen to provide aide services. The VA has agreements with local Area Agencies on Aging (AAA)[27] to administer the program, including providing case management services and oversight of budget.

[27] Established under the Older Americans Act, Area Agencies on Aging (AAAs) serve as local entities who, either directly or through contract with local service providers, oversee a comprehensive and coordinated service system for the delivery of home and community-based services to older individuals. For further information, see CRS Report R43414, *Older Americans Act: Background and Overview*, by (name redacted) and (name redacted)

Table 3. Non-Institutional Care Provided or Purchased by the VA

Program	Description	Administrative Eligibility	Clinical Eligibility
Care Provided by the VA			
Home Based Primary Care (HBPC)	Comprehensive, long-term primary care provided by an interdisciplinary team that makes home visits	Available to all veterans enrolled in VHA and actively receiving health care services	Veterans who have any of the following: • impaired mobility making it difficult to leave home; • inability to cope with clinic environment due to cognitive, physical, or psychiatric impairment; • need for frequent coordinated interventions from multiple disciplines; or • recurrent hospitalizations
Community Residential Care (CRC)	Supported housing, where veterans reside in an approved group home with supervision; VA staff provide case management and monitor care	Same as HBPC	Veterans who cannot live independently because of medical or psychiatric conditions, requiring monitoring, supervision, and assistance with household tasks
Medical Foster Home (MFH)	Supported housing providing a higher level of care than a CRC; veterans reside in an approved adult foster care setting with private citizen caregiver providing 24/7 supervision; VA interdisciplinary care team makes home visits, and an MFH Coordinator monitors care	Available to all veterans enrolled in VHA and actively receiving health care services, IF their local VA has a MFH program	Veterans who meet nursing home level of care and cannot live safely in the community; need for and willingness to accept interdisciplinary care, such as HBPC
Geriatric Evaluation	Comprehensive, interdisciplinary assessment and development of plan of care	Same as HBPC	Veterans who are typically aged 65+ and have multiple medical, functional or psychosocial issues requiring interdisciplinary approach, or geriatric syndromes (e.g., dementia, polypharmacy, incontinence, malnutrition, depression, falls)
Palliative Care	Comfort care, including but not limited to hospice care provided in both inpatient and outpatient settings, focusing on symptom management	Same as HBPC	Veterans who have a chronic, life-limiting condition and desire care focused on symptom management, quality of life; veteran may still be receiving curative treatment

Program	Description	Administrative Eligibility	Clinical Eligibility
Care Provided by the VA or Care Purchased by the VA from Community Agencies			
Adult Day Health Care (ADHC)	Services provided in an outpatient day program where veterans can spend the day and have activities, socialization, and nursing care, in a congregate setting	Available to all veterans enrolled in VHA and actively receiving health care services (may be operated by VA or purchased by VA)	Veterans who have dependencies in three or more ADLs *or* significant cognitive impairment *or* require care as adjunct to home hospice services *or* two ADL dependencies and any two of the following: • three IADLs dependencies; • recent nursing facility discharge; • age 75 or older; • three hospitalizations in a year; • clinical depression diagnosis
Care Purchased by the VA from Community Agencies			
Homemaker/Home Health Aide (H/HHA)	Services of a home health aide provided in the home, such as personal care assistance with bathing, dressing, transferring	Same as HBPC	Same as ADHC
Non-Institutional Respite	Services of an aide provided in the home on a short-term basis or at an ADHC, to give the family caregiver a break from caring for the veteran; generally limited to 30 days per calendar year	Same as HBPC	Same as ADHC
Skilled Home Care	Time-limited services with the goal of restoring/rehabilitating the veteran's health, such as skilled nursing care, physical therapy, occupational therapy, and IV therapy	Same as HBPC	Veterans who need skilled nursing or rehabilitative therapy services, as ordered by a health provider
Home Hospice	Comfort care services provided by community hospice agencies for a veteran diagnosed with a life-limiting illness	Same as HBPC	Veterans who are diagnosed with life-limiting illness (with life expectancy of six months or less, as determined by physician) and accepting of comfort care rather than curative treatment

Program	Description	Administrative Eligibility	Clinical Eligibility
Veteran Directed Home and Community Based Services (VD-HCBS)	Veterans are given a flexible budget for services, which the veteran or family caregiver manages; veteran decides how to use budget to hire aides and/or receive services to help live independently in the community; the VA contracts with the local Area Agency on Aging to monitor the care	Available to all veterans enrolled in VHA and actively receiving health care services, *if* their local VA has a Veteran-Directed program	Same as ADHC; veterans must also be capable and interested in directing their own care or have family member who can direct care

Sources: VHA Hand book 1141.01 January 31, 2007, "Home-Based Primary Care Program"; VHA Handbook 1140.01 February 10, 2014, "Community Residential Care"; VHA Handbook 1141.02 November 10, 2009, "Medical Foster Home Procedures"; VHA Handbook 1140.04 May 13, 2010, "Geriatric Evaluation and Management (GEM) Procedures"; VHA Handbook 1140.09 December 2, 2009, "Geriatric Consultation"; VHA Directive 2008-066 October 23, 2008, "Palliative Care Consult Teams (PCCT)"; VHA Handbook 1141.03 September 29, 2009, "Adult Day Health Care"; VHA Handbook 1140.6 July 21, 2006, "Purchased Home Health Care Services and Procedures"; VHA Handbook 1140.02 November 10, 2008, "Respite Care"; VHA Handbook 1140.5 March 1, 2005, "Community Hospice Care: Referral and Purchase Procedures"; VHA Handbook 1140.11 November 4, 2015, "Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics."

Notes: Activities of Daily Living (ADLs) are tasks of personal care, such as bathing, dressing, toileting, transferring, and feeding oneself; Instrumental Activities of Daily Living (IADLs) are household tasks such as housekeeping, meal preparation, laundry, grocery shopping, transportation, and managing finances.

Institutional Care

As the VA works to support veterans in their home environment, some veterans may have long-term care needs that can be served in institutional settings (see **Table 4**). The VA is mandated to provide nursing home care to certain *service-connected veterans*.[28] As previously mentioned, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) requires the VA to provide nursing home care to the following veterans:

- any veteran in need of such care for a service-connected disability; or
- to any veteran who is in need of such care and who has a service-connected disability rating of 70% or more; or
- any veteran who has a service-connected disability rated 60% or more and unemployable; or
- any veteran who has a service-connected disability rated 60% or more and who has been rated permanently and totally disabled.[29]

Depending on available resources, the VA may also provide nursing home care to nonservice-connected veterans who are clinically in need of institutional care. This care may be provided in a VA Community Living Center (CLC), a Community Nursing Home (CNH), or a State Veteran's Home.

The VA has 135 Community Living Centers (CLC) associated with VAMCs across the country that provide nursing home level of care. CLCs are staffed by VA employees and may provide rehabilitation, custodial, and hospice care to veterans. Some CLCs may offer specialty services, such as a specialized dementia unit. In the mid-2000s, this program underwent a change in the model of care, renaming the facilities from Nursing Home Care Units to Community Living Centers to evoke a more homelike atmosphere and acknowledge that CLCs are the veterans' home. In addition to the name change, the VA launched a system-wide program to promote cultural transformation, including a more person-centered approach, more homelike interior design, and more resident choice related to daily schedule of meals, sleep and wake times, and bathing. CLCs are inspected by the VA's Office of the Inspector General and the Long-Term Care Institute.

While not all VAMCs have CLCs, all are required to operate a Community Nursing Home (CNH) program. Under this model, the VA has contracts with community nursing facilities to provide care to veterans. The VA inspects the nursing facility initially and then reviews quality annually, and VA clinical staff make monthly visits to each nursing facility where veterans have been placed to monitor the care being provided. The VA Community Nursing Home Coordinator makes arrangements for placement of eligible veterans and acts as a liaison for the nursing facility.

The third setting for VA nursing home care is in a State Veterans Home (SVH). SVHs are owned and operated by the state in which they reside, and eligibility requirements are determined by the state of jurisdiction. The state may apply for grants from the VA to cover some of the cost of

[28] See Title 38 U.S.C. §1710A.

[29] 38 U.S.C. §1710A. A permanently and totally disabled rating is based on an adjudication by the VA, where the service-connected disability rating is total (any impairment of mind or body that is sufficient to render it impossible for the average person to follow a substantially gainful occupation) for the purposes of VA disability compensation and where the impairment is reasonably certain to continue throughout the life of the disabled veteran (38 U.S.C. §1502; 38 C.F.R. §3.340).

infrastructure, and the SVH may receive a per diem that covers approximately one-third of the cost of the veteran's care. The VA also surveys the SVH annually. Each state operates SVHs differently, but may offer various levels of care in addition to nursing home, such as domiciliary (independent living), assisted living, and adult day health care.

In addition to providing long-term care in these settings, VA facilities may choose to provide respite, hospice, and palliative care, as well as geriatric evaluation programs, to eligible veterans in an institutional setting. As previously mentioned, veterans are eligible for 30 days of respite care per calendar year, in general; if needed, this care may be provided in an institutional setting (such as CLC or CNH), depending on resource availability, to give the family caregiver a break from caregiving. The clinical criteria for veterans receiving institutional respite care is the same as for home respite; however, this program may be limited in certain VA facilities depending on resource or bed availability. In addition, hospice care may be provided to veterans in an institutional setting. For example, veterans receiving home hospice whose care needs can no longer be managed at home may move into a VA CLC to receive hospice care for a short time, while their symptoms are managed, or while they are actively dying. In some cases, the VA may also pay for inpatient hospice care in other institutional settings, such as community inpatient hospice facilities. Also, palliative care may be offered in institutional settings; some CLCs may have palliative care units, or a VA may have a palliative care team that consults at the bedside of veterans in a hospital intensive care unit. Similarly, geriatric evaluation teams may consult with veterans residing in acute inpatient settings. Although the provision of these programs varies across VA facilities, the programs should be available to eligible veterans residing in institutional settings.

Table 4. Institutional Long-Term Care

Program	Description	Administrative Eligibility	Clinical Eligibility
Community Living Centers (CLC)	Nursing home facilities owned and operated by the VA	Veterans who require nursing home care for a service-connected condition; *or* who have 70% or more service-connected disability and who require nursing home care; *or* 60% service-connected and rated unemployable by the VA; *or* 60% service-connected and rated permanently and totally disabled by the VA; *or* on a case-by-case basis. Some VAs may provide CLC care to nonservice-connected veterans, particularly veterans requiring hospice care	Veterans must meet nursing home level of care for either rehabilitation or custodial care; for custodial care, veteran has dependencies in three or more ADLs, or significant cognitive impairment, or requires care as adjunct to home hospice services, or two ADL dependencies and any two of the following: • three IADLs dependencies; • recent nursing facility discharge; • age 75 or older; • three hospitalizations in a year; • clinical depression diagnosis
Community Nursing Home (CNH)	VA-contracted community nursing facilities that provide care to veterans; VA pays for and monitors care with monthly onsite visits and annual facility inspections	Same as CLC	Same as CLC
State Veterans Home (SVH)	State owned and operated nursing facilities for veterans (states may also offer domiciliary, adult day, or assisted living level of care)	Eligibility varies from state to state, and is determined by each state	Eligibility varies from state to state, and is determined by each state; generally, follows the state laws related to nursing home level of care

Sources: VHA Handbook 1140.11 November 4, 2015, "Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics"; VHA Handbook 1143.2 June 4, 2004, "VHA Community Nursing Home Oversight Procedures"; VHA Handbook 1145.01 May 17, 2010, "Survey Procedures for State Veterans Homes (SVH) Providing Nursing Home and Adult Day Health Care."

VHA Long-Term Care Expenditures

Long-term care expenditures are a small but not insignificant part of the VHA medical care budget, at just over one-tenth of the VHA's total medical care budget. In FY2015, the VHA spent $7.4 billion, just over 13% of its total medical care spending ($55.8 billion), for veteran's long-term care (see **Table 5**).[30] Institutional care accounted for almost $5.3 billion, or 71% of VA's total long-term care spending, while non-institutional care accounted for $2.1 billion, or 29%. While total appropriated funding for VHA medical care has increased 25% (in nominal dollars) since FY2010, the proportion of total appropriations spent on long-term care has remained relatively unchanged. However, non-institutional long-term care expenditures doubled from FY2010 to FY2015 (non-inflation adjusted dollars). As a proportion of total VA long-term care spending, non-institutional care increased from 19% to 29% from FY2010 to FY2015. As **Table 5** shows, the percentage of total VHA medical care spent on long-term care ranged from approximately 12% to 13% from FY2010 to FY2015.

Table 5. VHA Medical Care (Appropriations) and VHA Long-Term Care (LTC) Expenditures (Obligations), FY2010-FY2015

($ in thousands, non-inflation adjusted)

	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Total VHA Medical Care[a]	$44,496,500	$48,064,182	$50,610,985	$52,704,033	$54,358,000	$55,806,568
Total VHA LTC	$5,545,438	$5,970,304	$6,057,113	$6,224,808	$6,539,122	$7,415,391
Institutional[b]	$4,514,303	$4,815,099	$4,903,831	$4,985,689	$5,045,776	$5,288,308
Non-Institutional[c]	$1,031,135	$1,155,205	$1,153,282	$1,239,119	$1,493,346	$2,127,083
Total VHA LTC as % of Total VHA Medical Care	12.5%	12.4%	12.0%	11.8%	12.0%	13.3%

Source: FY2015 figures are from the Department of Veterans Affairs, FY2017 *Budget Submission, Medical Programs and Information Technology Programs, Volume II*, February 2016, pp. VHA-87-88. Numbers for previous fiscal years were obtained from similar VA budget submissions to Congress for FY2012-FY2016; the number for each fiscal year is taken from the budget submission two years later (e.g., the FY2015 number is from the FY2017 budget submission).

a. Total VHA medical care appropriations includes funding for the medical services, medical administration, and medical facilities accounts, and excludes medical and prosthetic research funding and medical care collections.

b. Institutional care includes VA Community Living Centers (CLSs), State Nursing Homes, and contracted community nursing homes; it excludes state home domiciliary programs.

c. Non-institutional care includes VA Adult Day Health Care; Home-Based Primary Care; State Adult Day Health Care; Community Adult Day Health Care; Home Respite Care; Purchased Skilled Home Care; Hospice Care; Community Residential Care; and Homemaker/Home Health Aide program; it excludes Spinal Cord Injury Home Care and Home Telehealth programs.

[30] Includes funding for the medical services, medical administration, and medical facilities accounts, and excludes medical and prosthetic research funding and medical care collections.

Institutional Care

The majority of VHA institutional care spending (64%) is for VA Community Living Centers (CLCs), which are nursing facilities owned and operated by the VHA (see **Table 6**). For FY2015, just over 9,000 veterans received care in CLCs. However, the majority of the "workload"—defined as the average number of veterans receiving nursing home care per day (or the average daily census)—was provided by state veterans' nursing homes, which are owned and operated by states.[31] Over half (53%) of the workload for FY2015 was accounted for by state veterans nursing homes. It is important to note that total medical care obligations for state nursing homes identified in **Table 6**, as well as per diem costs, account only for VA's portion of the total cost of care in state homes. States and veterans are also responsible for a share of the total costs of care in these settings.

Moreover, most VHA institutional spending pays for long-stay care. Across all institutional settings, 88% of residents were long-stay residents (defined as veterans residing in a setting for 91 days or more). Compared with other VA institutional settings, CLCs have higher per diem costs, on average, but also have a greater proportion of short-stay residents. Short-stay residents are more likely to need post-acute or rehabilitative care, which is often more resource-intensive than custodial nursing care provided to long-stay residents. **Table 6** compares FY2015 short-stay versus long-stay per diem costs by institutional setting. As shown in the table, average per diem rates for CLC short-stay in 2015 were greater than their average long-stay rates. According to the VA, CLCs may provide specialized care for veterans with mental or behavioral health conditions, as well as certain programs for those with dementia or spinal cord injuries.[32] In addition, CLC per diem costs account for other direct and indirect VA expenditures such as physician and other skilled medical staff, medical education and research, and overhead expenditures related to VA national programs.[33] These types of costs are not included in per diem costs for CNHs and state nursing homes.

Table 6. VHA Institutional Settings, FY2015

Institutional Setting	Total Medical Care Obligations ($ in thousands)	Average Daily Census	Short-Stay[a]		Long-Stay[b]	
			Average Daily Census	Per Diem Costs	Average Daily Census	Per Diem Costs
VA Community Living Centers (CLCs)	$3,377,088	9,226	2,371 (26%)	$1,184.01	6,855 (74%)	$940.19
State Nursing Homes[c]	$1,049,756	20,328	755 (4%)	$145.42	19,573 (96%)	$141.33
Community Nursing Homes (CNHs)	$861,464	8,311	1,599 (19%)	$309.77	6,712 (81%)	$277.84
Subtotal	$5,288,308	37,865	4,725 (12%)		33,140 (88%)	

[31] The concept and measure of "workload" was defined by GAO in the following report analysis: U.S. Government Accountability Office, *VA Nursing Homes: Reporting More Complete Data on Workload and Expenditures Could Enhance Oversight*, 14-89, December, 2013.

[32] Ibid., p. 16.

[33] Ibid., p. 22.

Source: Department of Veterans Affairs, *FY2017 Budget Submission, Medical Programs and Information Technology Programs, Volume II*, February 2016, pp. VHA-87-89; excludes expenditures for state home domiciliary programs, which typically provide residential rehabilitation and treatment services to veterans in need of mental health or substance use treatment.

Notes:

a. A short-stay is defined as 90 days or less.

b. A long-stay is defined as more than 90 days.

c. Total medical care obligations and per diem costs account only for VA's portion of the total cost of care. States and veterans are also responsible for a share of the total costs of care.

Non-Institutional Care

In FY2015, almost 70% of expenditures for long-term care provided in non-institutional settings were for either home-based primary care or homemaker/home health aide programs (see **Table 7**). The program that received the most visits or encounters (referred to as clinic stops/procedures in the table) was homemaker/home health aide programs. Services through homemaker/home health aide programs are provided more frequently, often several times a week, if not daily, to veterans who need ongoing assistance with personal care needs.

Table 7. Selected VHA Non-Institutional Care, FY2015

Non-Institutional Care	Total Medical Care Obligations ($ in thousands)	Clinic Stops (VA Care)/Procedures
Home-Based Primary Care	$750,575	1,275,258
Homemaker/Home Health Aide Programs	$721,119	10,020,422
Purchased Skilled Home Care	$319,249	1,825,750
Community Adult Day Health Care	$119,692	904,028
Hospice Care	$90,817	462,663
Community Residential Care	$74,296	71,024
Home Respite Care	$35,399	326,284
VA Adult Day Health Care	$14,905	123,661
State Adult Day Health Care	$1,031	38
Subtotal	$2.127,083	

Source: Department of Veterans Affairs, FY2017 Budget Submission, Medical Programs and Information Technology Programs, Volume II, February 2016, pp. VHA-87-89; excludes telehealth, spinal cord injury.

Notes: Clinic stops/procedures are the number of visits/encounters for a specific program in a specific area (clinic) over a designated period of time and do not represent the number of unique patients.

Issues for Congress

Three broad issues emerge for Congress when considering VA long-term care eligibility, financing, and delivery. The first issue is veterans' access to care, specifically access to long-term care services. The second issue is the setting where long-term care services are provided and the appropriate balance between home and community-based versus institutional services. The third issue involves veteran's health coverage options and federal coordination of financing and health care delivery within the VA health care system and across federal programs.

Access to Care

The veteran population, on average, is older than the general population. Further, the number of veterans who have disabilities that are rated as 70% or more service-connected, and therefore are eligible for VA-paid nursing home care, has increased. This growth may lead to more veterans needing access to long-term care services in order to remain in the community, as well as a greater number of veterans eligible for nursing home care at VA's expense. However, the current policy discussion has primarily focused on reforming access to care within the VA health care system, particularly in relation to primary and specialty care. The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), as amended, required two different external assessments of the VA.[34] The first was an independent assessment of the VA offering multiple broad recommendations for next steps for the VA.[35] The second assessment, conducted by the Commission on Care, made various recommendations regarding the future of the VA in a report published in July 2016.[36] Both sets of recommendations acknowledge the challenges associated with an increasing number of aging and disabled veterans, but they were largely silent on how such demographic implications will affect the demand for VA long-term care services. The VA's capacity to meet the needs of aged and disabled veterans over time depends on its ability to provide that care directly, but also to purchase care from the community.

This challenge raises several questions for policymakers: In the context of VA health system reform, are there access issues to be considered for long-term care as well as for specialty and primary care areas? How can the VA maximize quality and efficiency, recognizing that access to long-term care services and care coordination across acute and long-term care may prevent the frequency or need for more expensive care, such as acute inpatient stays or emergency department visits? Does the VA have the right size and mix of geriatric and extended care health professionals to meet the demands of the disabled and aging veteran population both now and in the future? Does the VA have the flexibility it needs to negotiate with community partners who provide much of VA's home and community-based care?

Institutional vs. Home and Community-Based Services

Over the past two decades, federal financing and delivery of long-term care, particularly for the largest federal payer of LTSS (Medicaid) has shifted toward the provision of care in home and community-based settings rather than institutional care. In FY1995, the proportion of Medicaid LTSS spending on institutional care was 82%, with 18% spent on home and community-based services (HCBS). Almost 20 years later, the proportion of Medicaid LTSS spending on institutional care has decreased to 47%, with more than half of spending (53%) on HCBS (data for FY2014).[37] Medicaid's shift toward more HCBS occurred with various administrative efforts and activities, as well as financial incentives and broader statutory authority from Congress for states to provide such services.[38] In part, Medicaid HCBS expansion was prompted by the U.S.

[34] See U.S. Congress, Committee of Conference, *Veterans Access, Choice, and Accountability Act of 2014*, Conference Report to accompany H.R. 3230, 113th Cong., 2nd sess., July 28, 2014, H.Rept. 113-564.

[35] The Centers of Medicare and Medicaid Alliance for Modernizing Health is operated by MITRE Corporation, in partnership with The RAND Corporation, McKinsey & Co., and Grant Thornton.

[36] Commission on Care, *Commission on Care Final Report*, Washington, DC, June 30, 2016, https://commissiononcare.sites.usa.gov (the report was issued publicly on July 5, 2016).

[37] Eiken, Steve, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY2014: Managed LTSS Reached 15 Percent of LTSS Spending*, April 15, 2016.

[38] For further information on Medicaid LTSS, see CRS Report R43328, Medicaid Coverage of Long-Term Services (continued...)

Supreme Court decision in *Olmstead v. L.C.*, which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). The movement to expand HCBS has occurred alongside the shift to more patient-centered and consumer-driven models of care, which seek to honor the preferences of the individual. Most individuals express a strong preference for remaining in their homes and communities rather than in institutions.[39]

Similarly, the VA has expressed a desire to move toward "a more balanced offering of home and community-based services".[40] However, in FY2015, 29% of VA long-term care spending was on non-institutional care versus 71% of spending on institutional care. One issue that may affect the balance of long-term care services offered is VA's statutory requirement to provide nursing home care to veterans with 70% or more service-connected disability, as well as the requirement to provide nursing home care to veterans who are service-connected and need care for their service-connected disability. Thus, similar to federal Medicaid statute, which requires states to provide nursing home care to certain eligible beneficiaries, the VA operates under a mandate to provide such care to certain veterans.

Moreover, the current design of the State Veterans Home (SVH) program generally favors institutional care over HCBS. As stated previously, under this federal-state partnership, the VA provides grants to states to build, modify, or acquire nursing home, domiciliary, and adult day health care facilities—a federal grant to the state may not exceed 65% of the total project cost.[41] In addition to providing grants to states for facility construction, the VA provides a fixed per diem to states for each veteran who receives care in a state veteran's home.[42] Thus, under the current program design, states generally have an incentive to continue to maintain long-term and extended care facilities rather than explore non-institutional alternatives.

According to the VA, HCBS is less costly than facility-based options and growth in LTSS expenditures can be moderated by moving toward the provision of more HCBS.[43] However, in the aggregate LTSS spending can be moderated only if HCBS spending increases as institutional spending decreases. VA's requirement to maintain a specific level of long-term care beds and staffing, as well as the mandate to provide institutional care to certain veterans, may create barriers to shifting care to HCBS.[44] To efficiently use the institutional resources it has, the VA must keep the institutional beds occupied. Further, whether beds are occupied or not, the cost to maintain the physical infrastructure of facilities owned and operated by the VA is a consideration.

(...continued)

and Supports, by (name redacted).

[39] AARP, "Home and Community Preferences of the 45+ Population," November 2010, http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf.

[40] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for FY2017*, 114th Cong., 2nd sess., March 2, 2016, pp. 163-164.

[41] 38 C.F.R. §Part 59.

[42] 38 C.F.R. §Part 51.

[43] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Military Construction, Veterans Affairs, and Related Agencies Appropriations for FY2017, 114th Cong., 2nd sess., March 2, 2016, pp. 163-164.

[44] VA has a statutory requirement to maintain the same level of institutional care and staffing as in FY1998 (an average daily census of 13,391 beds).Veterans Millennium Health Care and Benefits Act, P.L. 106-117. Codified at 38 U.S.C. §1710B(b). Also see U.S. Congress, Senate Committee on Veterans' Affairs, *An Open Discussion: Planning, Providing, And Paying For Veterans' Long-Term Care*, 109th Cong., 1st sess., May 12, 2005, S. Hrg. 109-240 (Washington: GPO, 2006), p. 39.

Current contracting requirements may limit the VA's ability to purchase institutional care in the community, thereby offsetting the need for institutional settings owned and operated by the VA. Such requirements may also limit the VA's capacity to provide care to veterans in their communities. Unless VA institutional spending can be reduced, spending on more HCBS may be an additional cost to the VA rather than a shift in cost.

This issue raises several questions for policymakers: What is the right proportion of VA LTSS spending on institutional versus non-institutional care? Does the VA have the appropriate number of CLC beds offering the right types of care? Does the VA have the ability and flexibility needed to partner with community long-term care facilities to provide care to veterans in their communities and potentially reduce demand for VA-owned and operated CLCs? Should Congress review the VA's long-term care infrastructure, comparing projected demand against capacity? And, finally, how might Congress compel the VA to shift care from institutions to home and community-based settings?

Coverage Options and Federal Coordination

Not all veterans rely on the VA exclusively for their health care. Many veterans access care through other sources of health coverage, and most veterans have more than one source of coverage. According to the 2015 VHA Survey of Enrollees, approximately 78% of veterans enrolled in the VHA have some type of public or private health care coverage in addition to VA health care. For example, 51% of veterans reported they were enrolled in Medicare, 7% had Medicaid, 19% had TRICARE, and 28% had private insurance (note that individuals may have reported more than one source of coverage). Only 20% of veterans surveyed reported having no other health coverage.[45]

Veterans with more than one coverage option may choose to access the VA instead of care covered under another health care program or insurer for a variety of reasons: personal preference, lower or no out-of-pocket costs (copayments) for certain services, or access to services that may not be available through traditional health insurance or Medicare. Veterans who have Medicare or private health insurance may seek services not covered by those plans from the VA, such as adult day health care or respite care. Although the VA offers some long-term care services similar to Medicaid (e.g., home health aides to assist with personal care), unlike Medicaid, the VA does not require veterans to spend down assets or meet strict income guidelines to receive long-term care. Conversely, some eligible veterans may elect other coverage options and choose to receive their health care in the community due to personal preference, proximity, or more timely access to a provider. Veterans' reliance on VA health care varies; some veterans rely solely on the VA, whereas others use the VA intermittently for certain health care services. This discrepancy presents a challenge for the VA in understanding current demand, and predicting future demand, for health care services. As veterans age, they may come to rely more on VA's long-term care services, which are not covered by Medicare or private health insurance.

Veterans enrolled in the VHA are likely to receive health care in other settings and through other forms of coverage. Coordination across federally financed health care programs is important to ensure efficient, appropriate, and high-quality health care. It is also critical to avoiding service duplication and overutilization—aspects that may further constrain VA's health care system resources and capacity. This raises several questions for policymakers: Where are there inefficiencies or duplication that could be limited or coordination that could be enhanced? When,

[45] Gasper, Joseph, et al., *2015 Survey of Veteran Enrollees' Health and Use of Health Care: Main Results Report*, December 11, 2015.

or for what services, should veterans access Medicaid, Medicare, and the VA? What do the VA and CMS know about veterans dually enrolled in Medicare or Medicaid and the VHA, or enrolled in all three programs, that could inform care coordination? How can the VA best plan for future demand when veterans have multiple care options and may ultimately seek none, some, or all of their care from the VA?

Appendix A. VHA Copayments for Long-Term Care Services

Veterans who are enrolled in the VA health care system do not pay any premiums; however, some veterans are required to pay copayments for certain services and outpatient medications related to the treatment of a nonservice-connected condition. **Table A-1** summarizes which Priority Groups are charged copayments for long-term care services. Only veterans in Priority Group 1 (those who have been rated 50% or more service-connected) and veterans who are deemed catastrophically disabled by a VA provider are never charged a copayment, even for treatment of a nonservice-connected condition. For veterans required to pay long-term care copayments, these charges are based on three levels of nonservice-connected care, including copayments for inpatient, non-institutional, and adult day health care. However, actual copayments may vary depending on a veteran's financial situation.

Table A-1. Copayments for Selected Long-Term Care Services, by Priority Group

(CY2016)

Priority Group	Long-Term Care Services (Daily Max)					
	Nursing Home Care/ Inpatient Respite Care/ Inpatient Geriatric Evaluation		Adult Day Health Care/ Outpatient Geriatric Evaluation/ Outpatient Respite Care		Home Based Primary Care/ Homemaker/ Home Health aide/ Home Skilled Care/Palliative Care	
	Service-Connected	Nonservice-Connected	Service-Connected	Nonservice-Connected	Service-Connected	Nonservice-Connected
1	$0	$0	$0	$0	$0	$0
2	$0	$0	$0	$0	$0	$0
3	$0	$0	$0	$0	$0	$0
4	$0	up to $97	$0	up to $15	$0	$0
5	$0	up to $97	$0	up to $15	$0	$0
6	$0	up to $97	$0	up to $15	$0	$15[a]
7	$0	up to $97	$0	up to $15	$0	$15
8	$0	up to $97	$0	up to $15	$0	$15

Source: CRS summary based on U.S. Department of Veterans Affairs, "2016 Copayment Rates" (IB 10-430), http://www.va.gov/HEALTHBENEFITS/resources/publications/IB10-430_copay_rates.pdf (dated January 2016). Accessed on March 15, 2016.

Notes: For more information on copayments, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by (name redacted) .

a. Some Priority Group 6 veterans do not pay copayments for certain types of care. For example, recent combat veterans in Priority Group 6 do not have copayments for care if the care is combat-related. Other Priority Group 6 veterans may be 0% service-connected for a condition, and do not pay copayments if the care is related to that service-connected condition.

Certain VA long-term care programs have associated costs other than a VA copayment. For example, regardless of service-connected status, veterans residing in Medical Foster Home or Community Residential Care homes pay out of pocket for room and board. The out-of-pocket cost varies by geographical area and amount of care needed. There is no additional VA copayment. Similarly, veterans who reside in State Veterans Homes may have out-of-pocket

costs; this varies from state to state and is often on a sliding fee scale. The payment is made to the State Veterans Home, and there is no additional VA copayment. Conversely, there is no copayment or cost to the veteran of any kind for VA hospice services, regardless of veterans' income or service-connected status.

Appendix B. Veterans Priority Groups

Figure B-1 lists the Veterans Priority Groups 1 through 8 and their eligibility criteria.

Figure B-1. Veterans Priority Groups and Eligibility Criteria

Priority Group 1

- Veterans with service-connected disabilities rated 50% or more disabling
- Veterans determined by VA to be unemployable due to service-connected conditions

Priority Group 2

- Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

- Veterans who are Former POWs[a]
- Veterans awarded the Purple Heart[b]
- Veterans in receipt of the Medal Of Honor[c]
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose previous year's gross household income (earned and unearned income) is below the established VA means test thresholds[d]
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- Compensable 0% service-connected veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with the following events:
  - Exposure to herbicides while serving in Vietnam between January 9, 1962, and May 9, 1975; or
  - Ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - Project 112/SHAD participants; or
  - For disorders associated with service in the Gulf War and who served between August 2, 1990, and November 11, 1998; or
  - For any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as follows:
  - Veterans discharged from active duty before January 27, 2003 and did not enroll on or before such date, for a three-year period beginning on January 27, 2008;
  - Veterans discharged from the active duty after January 27, 2003, for a five-year period beginning on the date of such discharge or release; or
  - Veterans discharged from active duty after January 1, 2009, and before January 1, 2011, but did not enroll during the five-year period of post discharge eligibility there is a one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act. (P.L. 114-2)
- Veterans who served on active duty at Camp Lejeune in North Carolina for not less than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, for any of the medical conditions specified in 38 U.S.C. 1710(e)(l)(F).

Priority Group 7

- Veterans who agree to pay specified copayments with income above the VA means test threshold and income below the VA national geographic income thresholds

Priority Group 8

- Veterans with gross household income above the VA and the means test threshold and the VA national geographic threshold. Priority Group 8 is further broken down into Subpriority Groups:
  - **Subpriority a:** Noncompensable 0% service-connected and enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status
  - **Subpriority b:** Noncompensable 0% service-connected and enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or VA national geographic income limits by 10% or less
  - **Subpriority c:** Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status
  - **Subpriority d:** Nonservice-connected veterans enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less
  - **Subpriority e:** Noncompensable 0% service-connected veterans not meeting the above criteria (currently not eligible for enrollment)
  - **Subpriority g:** Nonservice-connected veterans not meeting the above criteria (currently not eligible for enrollment)

Source: Prepared by CRS based on information from the U.S. Department of Veterans Affairs.

Notes:

a. Veterans who are former prisoners of war (POWs) are placed in Priority Group 3. This change occurred with the enactment of the Former Prisoner of War Benefits Act of 1981 (P.L. 97-37) on August 14, 1981.

b. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on November 30, 1999.

c. Veterans in receipt of the Medal of Honor are in Priority Group 3. This change occurred with the enactment of the Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) on May 5, 2010.

d. To align VA's health care program with other federal health care programs' financial assessment requirements, effective January 1, 2015, the VA stopped collecting veterans' net worth information for purposes of financial assessment for health benefits.

Author Contact Information

(name redacted)
Specialist in Health and Aging Policy
[redacted]@crs.loc.gov, 7-....

(name redacted)
Specialist in Veterans Policy
[redacted]@crs.loc.gov , 7-....

Acknowledgments

The authors would like to acknowledge Jamie Kuhne, 2016 Health and Aging Policy Fellow, for her invaluable contributions to the research and writing of this report.