



**STATEMENT BY**  
**RICHARD B. FULLER**  
**NATIONAL LEGISLATIVE DIRECTOR**  
**PARALYZED VETERANS OF AMERICA**  
**REGARDING**  
**LONG TERM CARE PROGRAMS OF THE DEPARTMENT OF VETERANS**  
**AFFAIRS AND IMPLEMENTATION OF PUBLIC LAW 106-117, THE**  
**VETERANS**  
**MILLENNIUM HEALTH CARE AND BENEFITS ACT**  
**BEFORE THE**  
**HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH**  
**May 22, 2003**

Mr. Chairman, thank you for inviting me to represent the members of Paralyzed Veterans of America (PVA) to present our views on the status of the Department of Veterans Affairs' (VA) long term care programs with particular emphasis of the VA's implementation, or lack there of, of the long term care provisions of Public Law 106-117.

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PVA works closely with the disability community and those groups representing seniors to advocate for a national policy for long term care protection. The United States is one of the few nations in the industrialized world that does not have a comprehensive program to cover the debilitating cost for its citizens facing extended care as a result of catastrophic injury, disease or age. Long term care programs in the United States are a patchwork of State and Federal Programs constantly under threat from deficit pressures and budget cutting, or stop gap proposals calling for tax deductions for extremely high cost long term care insurance premiums most Americans cannot utilize or afford. The crisis in American health care, the record numbers of the uninsured, the spiraling cost of health care, the drive to provide insurance coverage for prohibitively expensive prescription drugs, have driven long term care off the radar screen of most politicians. And yet, this problem facing millions of Americans and their families every day does not go away. In fact, the demand for long term care in whatever setting is going to increase dramatically, while the national response to this problem remains obscured.

I raise this national perspective to make the point that the same pressures facing federal and state governments in their response to long term care protection facing all Americans are also afflicting the VA and veterans. Ironically, assistive living and long term care were the primary mission of the series of veterans homes established following the War with Mexico and the Civil War in the mid-nineteenth century. Health care had been an incidental service in these facilities. One Hundred and fifty years later, VA provides a good quality health care service, but rising health care demand, soaring costs for services, prescription drugs, and chronic budget pressures have placed VA long term care services on the back burner of priorities for its health care professionals, managers and budgeteers. With major gaps widening in coverage for health care services in the private

and public sector across the United States, veterans could always look to VA as a safety net if they faced long term disability or illness. That is no longer the case.

In an attempt to shore up VA long term care services, the Congress, in 1998, approved P.L. 106-117 the Veterans Millennium Health Care and Benefits Act. The Act required VA to maintain its capacity of inpatient long term care beds at a level as of the date of enactment. The capacity legislation was designed to maintain bed levels. Its intent was to see that VA maintain the level of care provided in those beds. By VA's own admission it has failed to maintain that level of care. Average daily census, once 13,426 in 1998, dropped to 11,766 in 2003. The Administration's FY 2004 budget proposal would cut an additional \$198 million from this program, in effect, according to House Veterans' Committee Reports, cutting 900 FTEE from inpatient long term care programs, effectively eliminating an additional 5000 beds. From these statistics it is obvious VA has no intention of maintaining its nursing home capacity.

The public law gave a distinct eligibility for inpatient long term care services for veterans with service connected disabilities rated 70 percent or higher. PVA was concerned at the time that VA would construe this distinction for veterans with higher service connected ratings as meaning that all other veterans, not within that category, were not covered for VA nursing home care and effectively eliminated from eligibility for these services. Indeed, that has become the case in many locations. In reality, the impact of the law, requiring VA to maintain its inpatient long term care capacity, singularly implies that all categories of veterans are still eligible for long term care in nursing homes within that mandated capacity for VA to provide them. If there is

confusion on this matter within the VA, the Subcommittee should take steps to restate its original intent with additional legislation.

The Act also authorized eligibility for a wide range of services, alternatives to inpatient nursing home care, for all enrolled veterans. For many veterans and non-veterans with catastrophic disabilities, alternatives to being confined in nursing homes can be a true blessing. With the proper case management, home and community based care can provide a more humane and often less costly alternative to inpatient long term care. PVA welcomed this provision when it was enacted. However, VA has begun to implement this program, not as an alternative to inpatient long term care, but as an offset to required inpatient nursing home capacity levels. Worse, VA has been reducing inpatient levels saying that home and community programs would pick up that slack of that demand, and then totally failing to implement the alternative programs at required levels. We understand the GAO report presented at this hearing will document that fact.

PVA knows a lot about service capacity levels. With the help of this Subcommittee we were able to have a capacity requirement placed in statute mandating levels of beds and staff in VA spinal cord injury (SCI) centers. Prior to that time, SCI centers were under the same threat as nursing homes, subject to unilateral reductions in beds and staffing at the determination of local VA managers. The capacity requirement was written in much the same way the one for VA extended care beds and staff was written. However, only through constant pressure and vigilance were we able to have VA agree to those capacity requirements and maintain those levels.

Although it has come close, VA has never maintained the full staffing and bed levels agreed to in a directive sent from VA Central Office to the Field. One of the largest discrepancies has been in area of SCI long term care. Of 180 beds listed in the long term care area under our agreement, up until recently, VA still had to identify 60 of those beds. We have testified before this Subcommittee many times on this program. We are encouraged to say that after negotiations with VA, progress has been made to designate those outstanding inpatient long term care beds at specific locations across the country. These beds are to be designated either at existing SCI centers or at nursing homes affiliated with VA hospitals that also have SCI centers.

Long term care is a serious problem for PVA. Unlike an 80 year old who suffers a debilitating stroke and requires nursing home care, a 20 year old high level quadriplegic on a ventilator could be facing decades of extended care services. Where and how that person receives that care is always a difficult decision. Fortunately, VA has established the specialized services in VA SCI centers that can be found nowhere else in the United States. VA nursing homes can provide a level of care for such a complex patient, with the appropriate training and monitoring of VA care givers, that can never be purchased or found in the private sector. Also, at stake are the wishes of the veteran patient and his or her family. Careful determination needs to be made whether this person can be cared for properly at home, or closer to home. In that sense, assessments need to be made as to the consequence of the veteran's well-being and the veteran's family's well-being. The entire array of VA long term care services must be put into play, including respite care, home and community based care for this individual. But above all, VA needs to ensure that the veteran is receiving the appropriate care, by appropriately trained individuals, in the most appropriate setting.

VA must maintain all these options, whether for a veteran with a spinal cord injury or any other debilitating condition. The Department has developed and earned an excellent reputation in the quality and scope of its long term care services. Hopefully, this Subcommittee and the Congress will see to it that it does not abandon this unique and so essential mission.

I will be happy to respond to any questions you may have.



**Information Required by Rule XI 2(g)(4) of the House of Representatives**

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

**Fiscal Year 2003**

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation  
— National Veterans Legal Services Program— \$220,000 (estimated).

**Fiscal Year 2002**

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation  
— National Veterans Legal Services Program— \$179,000.

**Fiscal Year 2001**

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation  
— National Veterans Legal Services Program— \$242,000.

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## **RICHARD B. FULLER**

Richard B. Fuller is the National Legislative Director of the Paralyzed Veterans of America (PVA), a non-profit veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities. PVA's primary legislative focus centers on issues supporting the Department of Veterans Affairs health care system and the specialized services VA provides to PVA members. He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services, as well as oversight on all federal health systems – Medicare and Medicaid – and research activities which benefit veterans as well as all Americans with disabilities.

Mr. Fuller served for eight years on the professional staff of the Committee on Veterans' Affairs of the U.S. House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington, DC.

Mr. Fuller was Director of Public Affairs of the House Committee on Veterans' Affairs from 1979-1981. He served on the professional staff of the Subcommittee on Education, Training and Employment and for the Subcommittee on Hospitals and Health Care until 1987. In 1987, he joined the national government relation's staff of PVA, serving first as Associate Legislative Director, and then as National Legislative Director. In 1991, he joined a Washington D.C. health care consulting firm representing the public policy and legislative interests of several national medical and research societies, including: the American Federation for Clinical Research; the American Gastroenterological Association; the American Geriatrics Society; and the National Association of Veterans Research and Education Foundations. He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968-1972, stationed two and one-half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service.

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