



February 2020

# VA HEALTH CARE

## Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand

Accessible Version

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### Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand



Highlights of [GAO-20-284](#), a report to congressional committees

#### Why GAO Did This Study

Veterans rely on long-term care to address a broad spectrum of needs, from providing occasional help around the house to daily assistance with eating or bathing to round-the-clock clinical care. Veterans' eligibility for this care is primarily based on their service-connected disability status, among other factors.

Congress included a provision in statute for GAO to review VA's long-term care programs. This report (1) describes the use of and spending for VA long-term care and (2) discusses the challenges VA faces in meeting veterans' demand for long-term care and examines VA's plans to address those challenges.

GAO reviewed VA documents, such as strategic planning documents for long-term care programs and analyzed VA utilization and expenditure data for fiscal years 2014 through 2018 (the latest available at the time of the review) and projected data through 2037. GAO also interviewed officials from VA, including officials from VA's GEC, which is responsible for overseeing long-term care programs; and from Veterans Service Organizations.

#### What GAO Recommends

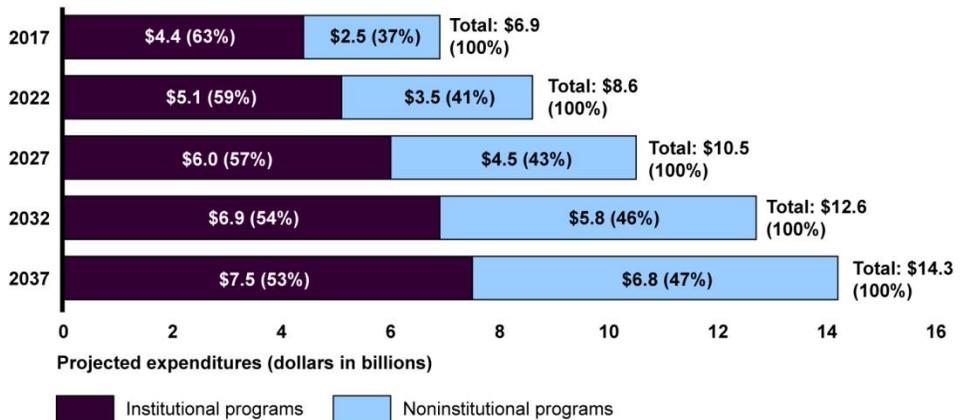
GAO is making three recommendations, including that VA develop measurable goals for its efforts to address key challenges in meeting the demand for long-term care. VA concurred with GAO's recommendations and identified actions it will take to implement them.

View [GAO-20-284](#). For more information, contact Sharon M. Silas at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov).

#### What GAO Found

The Department of Veterans Affairs (VA) provides or purchases long-term care for eligible veterans through 14 long-term care programs in institutional settings like nursing homes and noninstitutional settings like veterans' homes. From fiscal years 2014 through 2018, VA data show that the number of veterans receiving long-term care in these programs increased 14 percent (from 464,071 to 530,327 veterans), and obligations for the programs increased 33 percent (from \$6.8 to \$9.1 billion). VA projects demand for long-term care will continue to increase, driven in part by growing numbers of aging veterans and veterans with service-connected disabilities. Expenditures for long-term care are projected to double by 2037, as shown below. According to VA officials, VA plans to expand veterans' access to noninstitutional programs, when appropriate, to prevent or delay nursing home care and to reduce costs.

**VA Projections for Long-Term Care Expenditures, Fiscal Years 2017 through 2037**  
Fiscal year



Source: GAO analysis of projected VA expenditure data. | GAO-20-284

Note: These long-term care programs include those VA projects using its Enrollee Health Care Projection Model. This model includes 12 of VA's 14 Long-Term Services and Supports programs, excluding State Veterans Homes and State Home Adult Day Health Care.

VA currently faces three key challenges meeting the growing demand for long-term care: workforce shortages, geographic alignment of care (particularly for veterans in rural areas), and difficulty meeting veterans' needs for specialty care. VA's Geriatrics and Extended Care office (GEC) recognizes these challenges and has developed some plans to address them. However, GEC has not established measurable goals for these efforts, such as specific staffing targets for programs with waitlists or specific targets for providing telehealth to veterans in rural areas. Without measurable goals, VA is limited in its ability to address the challenges it faces meeting veterans' long-term care needs.

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# Contents

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Letter	1
Background	4
Utilization of and Spending for VA Long-Term Care Have Increased in Recent Years and Are Projected to Increase	11
VA Has Identified Several Key Challenges to Meeting the Demand for Long-Term Care, but Lacks Measurable Goals for Addressing Them	19
Conclusions	25
Recommendations for Executive Action	25
Agency Comments	26
<hr/>	
Appendix I: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Program Descriptions	28
Appendix II: Utilization and Obligations for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2014 to 2018	31
Appendix III: Projected Utilization and Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037	34
Appendix IV: Comments from the Department of Veterans Affairs	37
Agency Comment Letter	39
<hr/>	
Appendix V: GAO Contact and Staff Acknowledgments	41
GAO Contact	41
Staff Acknowledgments	41
<hr/>	
Appendix VI: Accessible Data	42
Data Tables	42
<hr/>	
Related GAO Reports	44

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Tables

Table 1: VA Identified Challenges to Meeting Department of Veterans Affairs' (VA) Projected Demand for Long-Term Care <sup>20</sup>	
Table 2: Department of Veterans Affairs' (VA) Institutional Long-Term Care Program Descriptions	28
Table 3: Department of Veterans Affairs' (VA) Noninstitutional Long-Term Care Program Descriptions	29
Table 4: Utilization for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2014 through 2018	31
Table 5: Obligations for Department of Veterans Affairs (VA) Long-Term Care Programs, Fiscal Years 2014 through 2018 <sup>33</sup>	
Table 6: Projected Utilization for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037	34
Table 7: Projected Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037	36

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Figures

Figure 1: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs	5
Figure 2: Number of Veterans Receiving Long-Term Care, by Various Characteristics, Fiscal Year 2018	9
Figure 3: Obligations for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2014 through 2018	14
Figure 4: Projected Expenditures for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2017 through 2037	18

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**Abbreviations**

EHCPM	Enrollee Health Care Projection Model
GEC	Geriatrics and Extended Care office
HAIG	Healthcare Analysis and Information Group
GPRA	Government Performance and Results Act
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Networks

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February 19, 2020

Congressional Committees

Veterans—like millions of other Americans—rely on long-term care to help meet their health or personal care needs for either discrete or sustained periods of time. Long-term care can address a broad spectrum of needs, from providing occasional help around the house to daily assistance with eating or bathing to extensive, round-the-clock clinical care. In fiscal year 2018, the Department of Veterans Affairs (VA) provided or paid for long-term care for over 500,000 veterans through 14 long-term care programs. Most veterans receive long-term care through noninstitutional programs in their homes or communities, while others receive more extensive care in institutional programs such as nursing homes. Veterans’ needs for long-term care vary, and VA Medical Centers (VAMC) help veterans and their families decide which programs may best meet an individual veteran’s needs.

As one of the largest health care systems in the United States, VA faces challenges similar to other health care providers when seeking to meet the growing need for long-term care as the U.S. population ages. For example, we have previously reported on workforce shortages in key positions—such as nationwide shortages of nursing assistants and home health aides—that are critical for supporting long-term care programs.<sup>1</sup> VA recognizes it faces challenges meeting the demand for long-term care and has taken some steps to address these challenges in its strategic planning process. For example, according to 2019 strategic planning documents, VA has pursued funding to expand some of the long-term care services accessible to veterans through telehealth.

The John S. McCain National Defense Authorization Act for Fiscal Year 2019 included a provision that we review the availability of VA’s long-term care programs for veterans, including future demand for, and VA’s capacity to provide, this care.<sup>2</sup> This report (1) describes the use of and

<sup>1</sup>See GAO, *Long-Term Care Workforce: Better information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers*, [GAO-16-718](#) (Washington, D.C.: Aug. 16, 2016).

<sup>2</sup>Pub. L. No. 115-232, § 738, 132 Stat. 1635, 1822.

spending for VA long-term care, and (2) discusses the challenges VA faces to meet veterans' demand for long-term care and examines VA's plans to address those challenges.

To describe the use of and spending for VA long-term care, we obtained and analyzed VA data and documents on the long-term care programs that are overseen by VA's Geriatrics and Extended Care office (GEC), and we interviewed VA officials about these programs.<sup>3</sup> Specifically, we reviewed VA data on the utilization of and obligations for long-term care programs for fiscal years 2014 through 2018 (the latest complete fiscal year data available at the time of our review) and projections of utilization and expenditures developed by VA's Enrollee Health Care Projection Model (EHCPM) for fiscal years 2017 through 2037.<sup>4</sup> For both time periods, VA's utilization data describe the workload units associated with providing long-term care. (These workload units may differ by program, such as the average daily census of veterans receiving care in institutional programs, or the number of community care visits provided by organizations that VA pays to provide care to veterans in noninstitutional programs.) We also obtained and analyzed VA data on the number of veterans who received care in VA's long-term care programs for fiscal years 2014 through 2018—including data on the number of unique veterans who received long-term care and specific characteristics such as

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<sup>3</sup>We include VA's Long-Term Services and Supports programs, which represent the majority of VA's obligations for long-term care, and for the purposes of this report, we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. Some veterans may also be eligible for placement in an Armed Forces Retirement Home which provides a continuum of care. For information on these types of homes, see GAO, *Older Americans: Continuing Care Retirement Communities Can Provide Benefits, but Not without Some Risk*, [GAO-10-611](#) (Washington, DC: June 21, 2010).

<sup>4</sup>VA data for fiscal years 2014 through 2018 were provided by VHA's Allocation Resource Center. VA officials told us that these data do not include non-veterans and may differ from data included in VA's congressional budget justification for a variety of reasons, including the timing of when they looked at the data, the inclusion of additional data, and that VA used a standard definition of services for all years. See Department of Veterans Affairs, *Volume II, Medical Programs and Information Technology Programs, Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations* (Washington, D.C.: Mar. 11, 2019).

VA projection data for fiscal years 2017 through 2037, which do not include projections for State Veterans Homes or State Adult Day Health Care programs, were provided by VHA's Office of Enrollment and Forecasting. These projections use base year 2017 data from a variety of sources that may differ from actual units and obligations that year, and we include 2017 because VA's 20-year projections are based on that year's data.

the number of veterans who served after September 11, 2001 who utilized these VA programs.

In terms of spending, VA reports information on its obligations, which refer to a definite commitment that creates a legal liability of the government to make a payment immediately or in the future; these obligations are incurred, for example, when the agency signs a contract, awards a grant, or purchases services. The EHCPM projects future expenditures, which refer to the actual spending of money to liquidate a federal obligation. Therefore, we report obligations for long-term care for fiscal years 2014 through 2018 and we report VA's EHCPM projections of expenditures for long-term care for fiscal years 2017 through 2037. We interviewed VA officials about all the data we reviewed, including officials from GEC and from VA's Office of Enrollment and Forecasting, and reviewed related documents about VA's long-term care programs. Based on our review of the data and documents, interviews with knowledgeable officials, and comparisons to other published reports, we determined the VA data were sufficiently reliable for our purposes of describing trends in the utilization of and spending for VA long-term care.

To discuss the challenges VA faces to meet veterans' demand for long-term care and examine VA's plans to address those challenges, we reviewed relevant VA documents and interviewed VA officials about VA's capacity to provide long-term care, including those from GEC and those from the Office of Policy and Planning responsible for strategic planning. Relevant documents we reviewed included VA policies, a 2018-2024 strategic planning document from VA, a 2018-2019 strategic planning document from the Veterans Health Administration (VHA), a 2019 strategic planning document from GEC, and internal reports. For example, we reviewed how VA and VHA's strategic goals related to long-term care were represented in GEC's strategic planning documents, and we reviewed a June 2019 report from VA's Healthcare Analysis and Information Group, a research group within VA, summarizing the results of its survey of VAMCs on long-term care issues. We also reviewed relevant articles and reports on long-term care challenges outside of VA to put VA's challenges in context. Further, we interviewed officials from four Veterans Service Organizations to gather their perspectives on VA's long-term care programs. We examined VA's plans to address challenges to meet veterans' demand for long-term care against relevant criteria from GAO's body of work on effectively managing performance under the Government Performance and Results Act of 1993 (GPRA), as enhanced by the GPRA Modernization Act of 2010, VA performance goals, and in the context of federal standards for internal controls related to the

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remediation of deficiencies and the timeframes for correcting deficiencies.<sup>5</sup>

We conducted this performance audit from April 2019 to December 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

For many veterans, long-term care is provided directly or purchased by VA. VA provides or pays for long-term care for eligible veterans enrolled in VA's health care through a variety of programs, including institutional-based care like nursing homes and noninstitutional programs like home health care, which provides care to veterans in their own homes.

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### VA Long-Term Care Programs

VA provides or pays for long-term care—ranging from assistance with dressing and bathing to clinical care for spinal injuries or dementia—through a range of three institutional and 11 noninstitutional programs. Institutional programs, such as nursing homes, typically provide more acute skilled nursing care in a residential facility; noninstitutional programs, such as the Home-Based Primary Care program, provide care to veterans in their homes or communities.<sup>6</sup> (See fig. 1 for a list of VA's institutional and noninstitutional long-term care programs and app. I for brief descriptions of these programs.)

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<sup>5</sup>GAO, *Managing For Results: Practices for Effective Agency Strategic Reviews*, GAO 15-602 (Washington, D.C.: July 29, 2015)

GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

<sup>6</sup>VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support program, and disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration.

**Figure 1: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs**

 **INSTITUTIONAL PROGRAMS**

- VA Community Living Centers
- Community Nursing Homes
- State Veterans Homes

 **NONINSTITUTIONAL PROGRAMS**

- Homemaker Home Health Aide
- Home-Based Primary Care
- Purchased Skilled Home Care
- Home Telehealth
- Community Adult Day Health Care
- VA Adult Day Health Care
- State Home Adult Day Health Care
- Home Hospice Care
- Home Respite Care
- Community Residential Care
- Spinal Cord Injury and Disability Home Care

Source: GAO analysis of VA documents. | GAO-20-284

Notes: We include all 14 of VA's Long-Term Services and Supports programs, which represent the majority of VA's obligations for long-term care, and for the purposes of this report, we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration.

**Institutional Programs.** VA provides or pays for eligible veterans to receive long-term care in three institutional programs that primarily provide skilled nursing care, such as for rehabilitation after surgery or for health issues or disabilities that require 24-hour care in a residential facility. These three programs include: VA Community Living Centers (VA-owned and -operated), Community Nursing Homes (publicly or privately owned and under contract with VA), and State Veterans Homes (state-owned and -operated homes approved and supported by VA).<sup>7</sup>

**Noninstitutional Programs.** VA provides or pays for eligible veterans to receive noninstitutional long-term care through 11 home or community-

<sup>7</sup>For more information on VA nursing home care, see GAO, *VA Nursing Home Care: VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website*, [GAO-19-428](#) (Washington, D.C.: July 3, 2019).

based programs, where most veterans receive long-term care. Several of VA's noninstitutional programs provide personal care assistance to help veterans with activities of daily living—e.g., dressing, eating, bathing—that enable veterans to remain living at home, including the Homemaker Home Health Aide, Community Adult Day Health Care, and Respite Care programs.<sup>8</sup> VAMCs evaluate veterans to determine the extent to which they can perform activities of daily living and to identify the available programs that would best meet their needs. In addition, VA's noninstitutional programs include the Community Residential Care program where caregivers—in settings such as Medical Foster Homes where no more than three residents receive care—provide 24 hour care for veterans who cannot live alone because of medical or mental health conditions.<sup>9</sup>

Several of VA's long-term care programs serve veterans with special needs. For example, some of these programs, such as certain Community Nursing Homes, Adult Day Health Care, and Hospice and Respite Care programs, have specially trained staff to serve veterans with dementia. The Spinal Cord Injury and Disability Home Care program and certain VA Community Living Centers are equipped to serve veterans

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<sup>8</sup>The Homemaker Home Health program includes the Veteran Directed Care program, which provides veterans with a flexible budget for services that can be managed by the veteran or the family caregiver.

Activities of daily living include assistance with dressing, eating, bathing, toileting, or transferring to or from bed. In addition, some VA programs also offer assistance with instrumental activities of daily living, such as preparing meals, housework, shopping, and transportation.

<sup>9</sup>VA's Community Residential Care program includes medical foster homes, assisted living homes, and family care homes which may serve specific populations of veterans. VA pays for veterans' health care services while veterans reside in the homes, and provides administrative support and oversight for veterans in these homes. The Veterans Millennium Health Care and Benefits Act authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling eligible veterans to secure needed assisted living services as an alternative to nursing home care." Pub. L. No. 106-117, § 103, 113 Stat. 1545, 1552 (1999).

A VA report to Congress found that assisted living could fill an important niche in the continuum of long-term care services. VA's congressional budget justification for fiscal year 2020 includes a legislative proposal that would authorize VA to pay for care in medical foster homes, which according to VA provide an alternative to nursing home care at a lower cost, to veterans for whom VA is required to provide nursing home care. As of November 2019, this proposal had not been enacted. Veterans Health Administration, *Evaluation of Assisted Living Pilot Program*, Report to Congress, July 2004.

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needing ventilator care. In addition, some programs offer specific services for younger veterans, such as certain Adult Day Health Care programs.

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## Eligibility for and Placement into VA Long-Term Care Programs

All veterans enrolled in the VA health care system are eligible for VA's basic medical benefits package, which includes certain institutional and noninstitutional long-term care services.<sup>10</sup> A veteran's eligibility for fully or partially covered nursing home care is determined by the veteran's priority for care, which is generally based on the veteran's service-connected disability status.<sup>11</sup> Specifically, VA must cover the full cost of nursing home care for veterans who need this care for a service-connected disability and for veterans with service-connected disabilities rated at 70 percent or more.<sup>12</sup> To the extent resources allow, VA may cover this nursing home care for certain other veterans, such as former prisoners of war and those awarded the Purple Heart.<sup>13</sup> For all other veterans, VA may generally cover nursing home care to the extent resources and capacity allow and with the veteran's agreement to share certain costs.<sup>14</sup>

Veterans' placement in any particular institutional or noninstitutional long-term care program may depend on their clinical needs, disability ratings, preferences, and the availability of VA programs. When funds are limited, the agency may prioritize program placement based on veterans' service-connected disability ratings. Decisions about which long-term care programs may be the best fit are made at the VAMC level between VA providers, veterans, and their families. VA providers may discuss a range of factors when making decisions about this care, such as health needs, the type of care provided in different programs, space availability,

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<sup>10</sup>38 C.F.R. §§ 17.36(a), 17.38(a)(1) (2019). See also U.S. Department of Veterans Affairs, *Federal Benefits for Veterans, Dependents and Survivors* (VA Pamphlet 80-18-01 P94663), 2018 Edition.

<sup>11</sup>VA determines service-connected disability ratings in 10 percent increments that are also used to place veterans into priority rating groups.

<sup>12</sup>This requirement expires on September 30, 2020, and is subject to the availability of appropriations. 38 U.S.C. § 1710A(a).

<sup>13</sup>38 U.S.C. § 1710(a)(2).

<sup>14</sup>38 U.S.C. §§ 1710(a)(3), 1710(f), 1710(g). Certain limitations apply.

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eligibility, and the veteran's geographic preference. For facility-based programs, VAMC staff may also encourage veterans to take a tour of the prospective home.<sup>15</sup> VA's stated goal is to honor veterans' preferences for care, including finding ways for veterans to age in their homes and communities instead of nursing homes.

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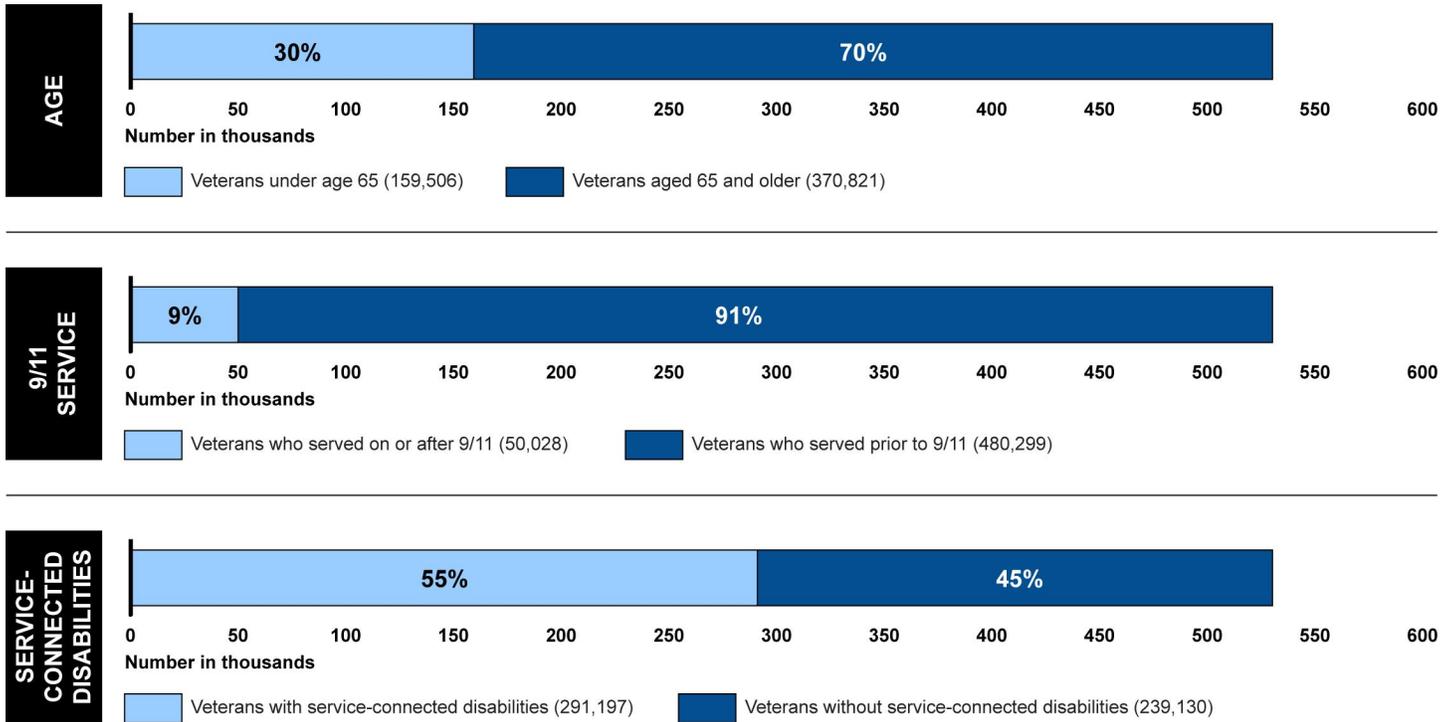
### Selected Demographics of Veterans in Long-Term Care

A diverse set of veterans receive care in VA's long-term care programs. According to VA data for fiscal year 2018, 70 percent (370,821) of the veterans who received VA long-term care during the fiscal year were aged 65 or older. (See fig. 2.) In addition, 91 percent (480,299) of those who received this care had served in the military prior to September 11, 2001. Lastly, according to VA data for fiscal year 2018, 55 percent (291,197) of veterans receiving long-term care had some level of service-connected disabilities.

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<sup>15</sup>VA's websites enable veterans and their families to learn more about long-term care options provided by VA or purchased in the community. VA's website, <https://www.va.gov/Geriatrics/>, includes information on its long-term care programs, and its *Access to Care* website, <https://www.accesstocare.va.gov/Healthcare/QualityOfCare>, provides additional information about the quality of care, both accessed Nov. 8, 2019. Also see [GAO-19-428](#).

**Figure 2: Number of Veterans Receiving Long-Term Care, by Various Characteristics, Fiscal Year 2018**



Source: GAO analysis of VA data. | GAO-20-284

## VA Planning for Long-Term Care

VA’s planning for veterans’ long-term care is informed by broader strategic planning by VA and the VHA and then operationalized by GEC at the program level. Veterans Integrated Service Networks (VISN) then implement GEC strategies for their regions and VAMCs implement and manage the various programs.

- VA, through the Assistant Secretary for Enterprise Integration’s office, sets a strategic plan that identifies agency-wide goals. For example, VA’s fiscal year 2018 through 2024 strategic plan identifies a goal that veterans “choose VA for easy access, greater choices, and clear information to make informed decisions,” and the plan notes that VA should “understand veterans’ needs throughout their lives to enhance

their choices and improve customer experiences.”<sup>16</sup> VA develops its agency-wide strategic plan every four years.

- VHA, through its Office of Policy and Planning, identifies strategies within VA’s health care system to address VA’s agency-wide goals. For example, VHA’s fiscal year 2018 through 2019 strategy, operationalizing VA’s goal for veteran choice, is to “honor veterans’ preferences by offering home and community based care to prevent unwanted nursing home care.” VHA strategic planning occurs every two years according to VA officials.
- VHA’s Office of Enrollment and Forecasting uses the EHCPM to project the utilization of and cost for care across most of VA’s health care programs 20 years into the future, including most long-term care programs.<sup>17</sup>
- GEC’s strategic planning operationalizes VA and VHA goals and strategies for long-term care at the program level. For example, to achieve VA’s goal of veteran choice and VHA’s strategy of honoring veteran preferences, GEC developed a model to identify veterans at the highest risk of needing nursing home care. According to GEC officials, the GEC strategic planning process generally occurs annually.
- VISNs are responsible for managing and overseeing VAMCs within their regions where long-term care is delivered, with a GEC point of contact at each VISN who can address GEC issues as they arise, according to VA officials.
- VAMCs within each VISN are, according to VA officials, responsible for the management of individual long-term care programs, including oversight of long-term care programs’ quality of care. As previously noted, VAMCs also have a role in guiding decisions about individual veterans’ long-term care placement.

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<sup>16</sup>Department of Veterans Affairs, *FY 2018–2024 Strategic Plan*, (May 31, 2019).

<sup>17</sup>VA’s EHCPM’s projections are based on (1) the projected number of veterans who will be enrolled in VA health care, (2) the projected quantity of health care services enrollees are expected to use, and (3) the projected unit cost of providing these services. Each of these components is subject to a number of complex adjustments to account for the characteristics of VA health care and the veterans who access VA’s health care services. VA uses other methods to estimate the care that veterans will use in state-operated programs, such as State Veterans Homes. For more information on VA’s estimates, see GAO, *VA Health Care: Estimating Resources Needed to Provide Community Care*, [GAO-19-478](#) (Washington, D.C.: June 12, 2019).

Other health care systems nationwide are also planning to meet the growing demand for long-term care and have developed strategies to address future long-term care challenges. For example, some state agencies, which provide long-term care through Medicaid, have developed strategies to help aging citizens live in their communities by enhancing community-based services and developing the workforce to provide care.<sup>18</sup> VA has a federal Geriatrics and Gerontology Advisory Group to share knowledge with other long-term care providers and to advise the Secretary and Under Secretary for Health on all matters related to geriatrics and gerontology for the care of veterans.<sup>19</sup>

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## Utilization of and Spending for VA Long-Term Care Have Increased in Recent Years and Are Projected to Increase

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### Utilization of VA Long-Term Care Increased from Fiscal Years 2014 through 2018

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Our analysis of VA data shows that the number of veterans receiving care in one or more of the VA long-term care programs increased 14 percent from fiscal years 2014 through 2018, from 464,071 to 530,327 veterans. The data also show that utilization increased more for noninstitutional programs than for institutional programs. Specifically by program type, VA data show that the number of veterans receiving institutional long-term care increased 8 percent during these years, from 97,124 to 105,151, while the number receiving noninstitutional care increased 16 percent,

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<sup>18</sup>For example, according to the Connecticut Department of Social Services, Connecticut established an initiative to rebalance long-term care to give seniors greater access to home and community based long-term care and reduce their reliance on institutional care. As part of the initiative, the state developed strategies—including use of data and analytics, improved access to primary care, integration of services, and workforce development—to improve health outcomes and cost efficiencies in their Medicaid program.

<sup>19</sup>The advisory group includes members with experience relevant to health care for aging veterans, including experience in VA and non-VA health systems. For example, in 2019, committee members included a member from a nursing home industry group and a recent chief executive officer of the American Geriatrics Society, among others. The group is tasked with assessing VA's ability to provide high quality geriatric and long-term care—including VA's ability to meet demand for care—and assessing the current and projected needs of veterans for geriatric and extended care, among other things.

from 395,736 to 459,783.<sup>20</sup> VA officials told us that the agency is continuing to expand veterans' access to noninstitutional care programs because institutional care is more costly than home- or community-based care, and because veterans prefer to delay or reduce the amount of nursing home care they receive.<sup>21</sup>

Our analysis showed that utilization of long-term care—in terms of various VA workload units—also generally increased from fiscal years 2014 through 2018.<sup>22</sup>

- The average daily census increased for two of VA's three institutional programs—Community Nursing Homes increased by 26 percent from 7,771 to 9,808 and State Veterans Homes increased by 1 percent from 23,176 to 23,423.<sup>23</sup>

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<sup>20</sup>Seven percent of the veterans who received VA long-term care during fiscal year 2018 received care in both institutional and noninstitutional programs.

<sup>21</sup>For example, we previously reported that the average cost of institutional care per veteran in Community Nursing Homes was \$268 per day, or almost \$98,000 per year, in fiscal year 2017. Our analysis of VA data show that the average cost per veteran receiving noninstitutional care was \$5,500 in that year, though that number reflects the average cost per day, per veteran, for care, which differs from the annualized cost stated above for Community Nursing Homes. Differences in cost may be the result of various factors, such as that institutional care includes room and board as well as 24-hour staffing and health care services, while noninstitutional care primarily consists of health care services. In addition, veterans receiving institutional care typically receive more acute nursing care. See [GAO-19-428](#).

<sup>22</sup>These utilization data generally describe the workload units involved in the delivery of care for each program, and units for each program may differ. For example, noninstitutional program workload units include VA clinic stops, which are defined as one patient encounter with a VA health care provider, where an individual patient may have multiple procedures or stops in a single visit or in one day, such as for a Home-Based Primary Care program visit with a VA nurse. These workload units also include community care visits measured by VA payments for specific codes that describe the purpose of a patient visit, such as a payment for a Home Hospice Care program visit from a community provider. Institutional program workload units use an average daily census that reflect the average number of veterans for which VA funded nursing home care on any given day during the year, such as a day in a community nursing home. The units for institutional and noninstitutional programs are not equivalent, and also differ from the number of veterans who received care.

<sup>23</sup>From fiscal years 2014 through 2018, of VA's three institutional long-term care programs, State Veterans Homes had the highest average daily census and provided over half of all institutional care based on the average number of veterans for which VA funded nursing home care on any given day during the year.

- Five of the 11 noninstitutional programs experienced increases in their workload over this period, ranging from 8 percent to 48 percent. For example, the number of VA clinic stops (one type of VA workload unit) in the Homemaker Home Health Aid program—which served approximately 23 percent of the veterans receiving noninstitutional long-term care in fiscal year 2018—increased 48 percent from 8.3 million to 12.3 million clinic stops. (See app. II for more information on veterans’ utilization of institutional and noninstitutional long-term care by program.)

According to VA, veterans’ use of VA long-term care programs increased during fiscal years 2014 through 2018 for several reasons, including that a large number of Vietnam veterans are aging and that more veterans are receiving higher service-connected disability ratings. We found the number of veterans who served on or after 9/11 and received VA long-term care to have increased at a faster rate than the overall number of veterans who received this care, from fiscal year 2014 through 2018.<sup>24</sup>

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### VA Spending for Long-Term Care Increased 33 Percent from Fiscal Years 2014 through 2018

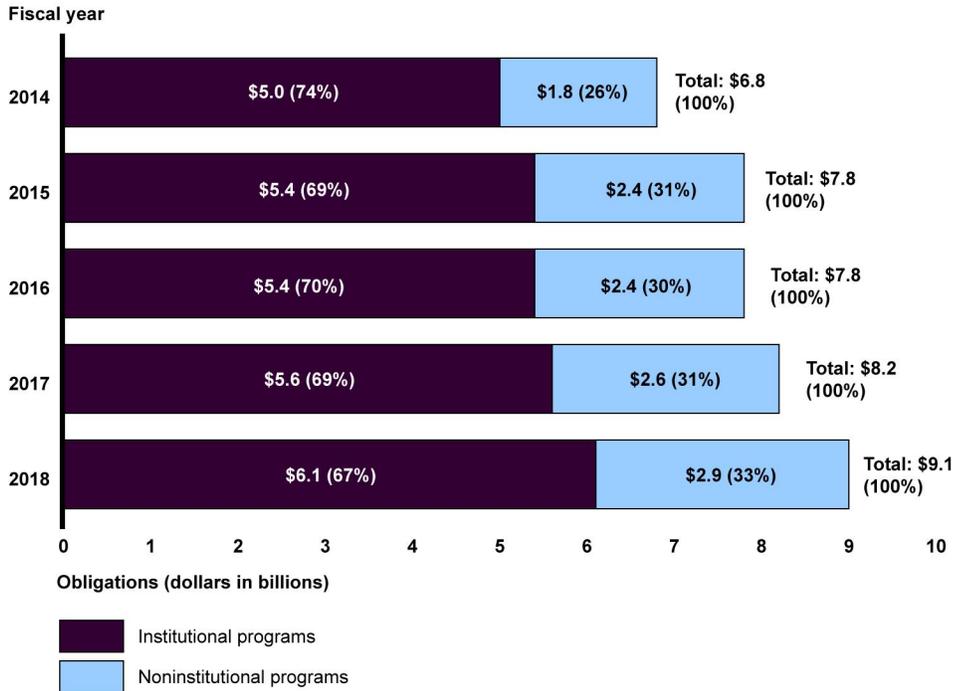
Our analysis of VA data shows that VA’s spending for long-term care—which VA reports as obligations—increased 33 percent, from \$6.8 billion in fiscal year 2014 to \$9.1 billion in fiscal year 2018.<sup>25</sup> Furthermore, over this time period institutional program obligations declined as a proportion of total obligations, from 74 percent to 67 percent, while the proportion of noninstitutional program obligations rose from 26 percent to 33 percent. (See fig. 3.)

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<sup>24</sup>Specifically, while the number of veterans who served on or after 9/11 represented 9 percent of the total number of veterans who received VA long-term care in fiscal year 2018, the number of these veterans who received long-term care increased 67 percent, from 29,975 to 50,028, from fiscal year 2014 through 2018. In contrast, the overall number of veterans who received VA long-term care during these years increased 14 percent.

<sup>25</sup>Adjusted for inflation, the increase would be 25 percent.

**Figure 3: Obligations for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2014 through 2018**



Source: GAO analysis of VA obligation data. | GAO-20-284

Notes: We include all 14 of VA's Long-Term Services and Supports programs, which represent the majority of VA's obligations for long-term care, and for the purposes of this report, we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. These programs are not reflected in this figure. Totals may not sum due to rounding.

Looking at VA's three institutional programs, our analysis shows VA's obligations for these programs increased 21 percent from fiscal years 2014 through 2018, from \$5.0 billion to \$6.1 billion.<sup>26</sup> The highest share of obligations for institutional care over this time period was for the VA Community Living Centers program, which increased 11 percent, from \$3.3 billion to \$3.7 billion.<sup>27</sup> This percentage increase was less than the increases for the Community Nursing Homes program (49 percent) and

<sup>26</sup>Adjusted for inflation, the increase would be 14 percent.

<sup>27</sup>Our analysis of VA data showed that obligations for VA's Community Living Centers during these years accounted for approximately two-thirds of VA's obligations for institutional programs. Adjusted for inflation, the increase would be 5 percent.

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the State Veterans Homes program (33 percent); however, costs for these last two programs are significantly lower than for the other institutional program.<sup>28</sup>

VA obligations for its 11 noninstitutional long-term care programs increased 66 percent, from \$1.8 to \$2.9 billion, between fiscal years 2014 and 2018.<sup>29</sup> Noninstitutional programs with the highest share of obligations during that period included the Homemaker Home Health Aide, Home-Based Primary Care, Purchased Skilled Home Care, and Home Telehealth programs. Noninstitutional programs with the highest obligation increases included the Homemaker Home Health Aide (109 percent) and Purchased Skilled Home Care (164 percent) programs.<sup>30</sup> However, two noninstitutional programs saw obligations decline during these years, including the State Home Adult Day Health Care program with a 59 percent decrease, and the Community Residential Care program with a 10 percent decrease.<sup>31</sup> (See app. II for more information on VA's obligations for institutional and noninstitutional long-term care by program.)

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<sup>28</sup>Adjusted for inflation, these increases would be 40 and 25 percent, respectively.

We previously reported that the average cost per day for veterans' care in each institutional program varied significantly due to differences in costs for each program. Specifically, in fiscal year 2017 the average cost per day for veterans' care was \$1,074 in a VA community living center, \$268 in a community nursing home, and \$166 in a state veterans home. For more information see [GAO-19-428](#).

<sup>29</sup>Adjusted for inflation, the increase would be 56 percent.

<sup>30</sup>Adjusted for inflation, these increases would be 97 and 148 percent, respectively.

<sup>31</sup>Adjusted for inflation, these decreases would be 61 and 15 percent, respectively. In VA's comments on a draft of this report, VA noted that while the overall use of Community Residential Care programs is declining, the use of Medical Foster Home programs, part of the Community Residential Care program, is increasing.

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## VA Projects Utilization of VA Long-term Care to Increase from Fiscal Years 2017 through 2037

VA projects utilization of long-term care will increase for most of the programs included in VA's EHCPM from fiscal years 2017 through 2037.<sup>32</sup>

- For the two institutional programs included in the EHCPM, VA projects that utilization based on workload units (average daily census) will increase by 80 percent for the Community Nursing Homes program but will decrease by 10 percent for the Community Living Centers program.<sup>33</sup>
- For the 10 noninstitutional programs included in the EHCPM, VA projects that utilization based on workload units (which differ by program) will increase for nine of the 10 programs—with increases ranging from 1 percent to 95 percent. For example, the number of VA clinic stops for the Homemaker Home Health Aide program is projected to increase 84 percent. (See app. III for more information on projected utilization for institutional and noninstitutional long-term care by program.)

VA reports that these projections are based on expected increases in the number of veterans who will rely on VA for their long-term care needs

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<sup>32</sup>VA's EHCPM utilization data generally describe the workload units involved in the delivery of care for each program, rather than the number of veterans who will receive care. This model does not project utilization or expenditures for state-operated programs, specifically, the State Veterans Homes and the State Adult Day Health Care programs. VA's EHCPM projections are based on 2017 data from a variety of sources, so fiscal year 2017 data reported earlier in this report may differ from projected data for that year. VA officials also told us that these data may differ from data included in VA's congressional budget justification for a variety of reasons, including that VA's projections rely on data and information from a variety of sources, such as historic data and modeling assumptions, and do not reflect the full unit cost of the services.

<sup>33</sup>As described earlier, noninstitutional program workload units include VA clinic stops, which are defined as one patient encounter with a VA health care provider, where an individual patient may have multiple procedures or stops in a single visit or in one day, such as for a Home-Based Primary Care program visit with a VA nurse. These units also include community care visits measured by VA payments for specific codes that describe the purpose of a patient visit, such as a payment for a Home Hospice Care program visit from a community provider. Institutional program workload units use an average daily census that reflect the average number of veterans for which VA funded nursing home care on any given day during the year, such as a day in a community nursing home.

through fiscal year 2037.<sup>34</sup> According to VA officials, these projected increases are due to a variety of factors, including that VA plans to continue expanding the availability of home- and community- based care, and plans to provide care to an increasing number of aging veterans and veterans rated in the highest service-connected disability groups. For example, VA data show that the proportion of long-term care provided to veterans with service-connected disabilities is projected to increase from 60 percent to 78 percent of utilization from fiscal year 2017 to 2037, and the proportion of this care provided to post-9/11 deployed combat veterans is projected to increase from 1 percent to 6 percent of all long-term care utilization during these years. Further, VA officials told us that the agency has planned to expand veterans' access to noninstitutional care when appropriate, and they have integrated these assumptions into the EHCPM.

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### VA Projects Expenditures for Long-Term Care to Increase from Fiscal Year 2017 through 2037, with Noninstitutional Programs Accounting for an Increased Share of Expenditures

VA projects that increases in overall demand for long-term care for veterans will result in future expenditure increases for the programs included in VA's EHCPM.<sup>35</sup> Specifically, VA's model projects expenditures will more than double from fiscal years 2017 through 2037, increasing from \$6.9 billion to \$14.3 billion (107 percent).<sup>36</sup> VA projects that its expenditures for its institutional programs will be higher than for its

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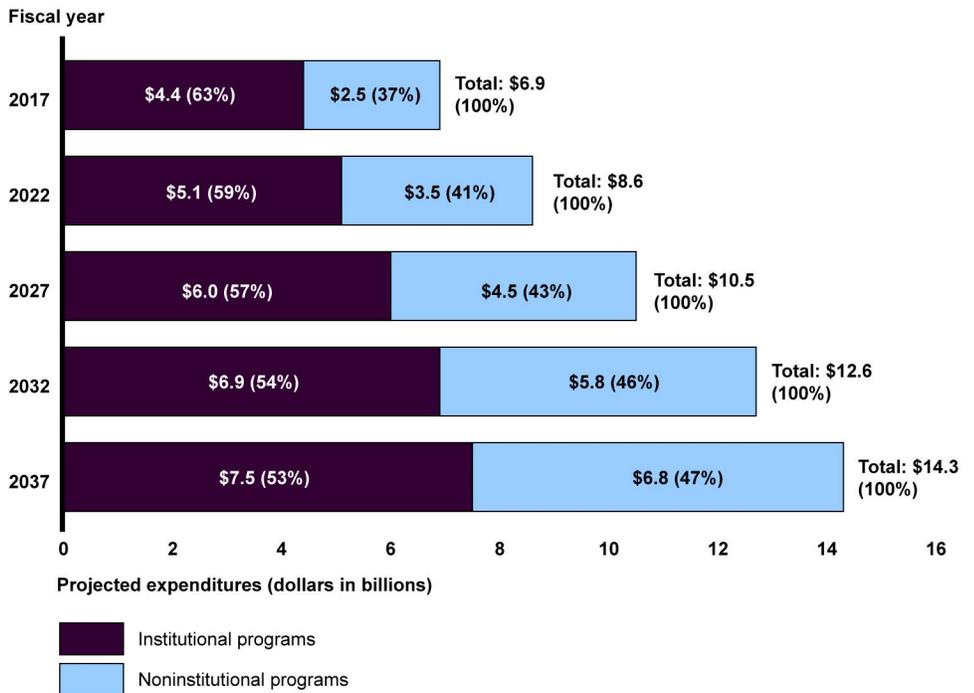
<sup>34</sup>VA reports that projections are based on a variety of information, including on changes in policy, the veteran population, veterans' geographic locations, ages, health issues and other information. Veterans' projected reliance on VA for long-term care also takes into account veterans' reliance on other sources of care, such as Medicare and Medicaid.

<sup>35</sup>As noted earlier, we report on projected expenditures, rather than obligations, as VA's EHCPM estimates projected spending as expenditures. In contrast, we report on VA's obligations for prior year spending. VA's reported obligations of \$8.2 billion for fiscal year 2017 differ from its projected expenditures of \$6.9 billion for fiscal year 2017 for a variety of reasons, including that its projections do not include the State Veterans Homes or the State Home Adult Day Health Care programs. In addition, VA's projected expenditures incorporate assumptions about future inflation and changes in medical care. For example, VA reports that inflation trends account for increases in labor and supply costs, and intensity trends reflect expected changes in the cost mix of services from evolving medical care practices and advances in technology.

<sup>36</sup>Part of this increase reflects inflation over time. Using projections from the Congressional Budget Office, for example, prices are expected to rise by 49 percent during the same period.

noninstitutional programs, reaching \$7.5 billion and \$6.8 billion, respectively, by fiscal year 2037. However, VA also projects that the proportion of expenditures for institutional long-term care will decrease from 63 percent to 53 percent, as the share for noninstitutional programs increases. (See fig. 4.)

**Figure 4: Projected Expenditures for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2017 through 2037**



Source: GAO analysis of projected VA expenditure data. | GAO-20-284

Notes: These long-term care programs include those that VA projects using its Enrollee Health Care Projection Model based on fiscal year 2017 data. This model includes 12 of the VA's 14 Long-Term Services and Supports programs, excluding State Veterans Homes and State Home Adult Day Health Care. Totals may not sum due to rounding.

While VA expenditures are projected to increase for all long-term care programs included in the EHCPM from fiscal years 2017 through 2037, the size of these projected increases vary by program. For example, VA projects its expenditures for institutional programs to increase 71 percent overall over this time period, with the VA Community Living Centers program projected to increase 50 percent and the Community Nursing Homes program to increase 149 percent. VA projects that its expenditures for noninstitutional programs will increase 168 percent over this time, with the largest projected increases including the Community

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Adult Day Health Care (240 percent), Home Respite Care (231 percent), and the Homemaker Home Health Aide (212 percent) programs. (See app. III for more information on projected expenditures for institutional and noninstitutional long-term care by program.)

The projected expenditures for care provided to veterans with service-connected disabilities are projected to represent a growing percent of VA's long-term care expenditures, increasing from 64 percent to 79 percent of expenditures for this care from fiscal years 2017 through 2037. VA projects that its expenditures for care provided to veterans with service-connected disabilities will increase 156 percent during this period, from \$4.4 billion to \$11.3 billion, while expenditures for care provided to veterans without service-connected disabilities will increase only 19 percent, from \$2.5 billion to \$3.0 billion. In addition, VA projects that the proportion of spending for long-term care provided to post-9/11 deployed combat veterans will rise from 1 percent to 7 percent during these years, from \$89 million to \$981 million, as that cohort of veterans ages.

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## VA Has Identified Several Key Challenges to Meeting the Demand for Long-Term Care, but Lacks Measurable Goals for Addressing Them

As VA works to meet veterans' growing demand for long-term care, it faces a number of key challenges: workforce shortages, geographic alignment of care, and difficulty meeting veterans' needs for specialty care. (See table 1.) These challenges, which VA has identified, are similar to challenges faced by other health care systems. However, while VA's GEC—the office that manages VA long-term care programs—is aware of these challenges, as of November 2019 GEC's strategic planning has not identified measurable goals for addressing them.

**Table 1: VA Identified Challenges to Meeting Department of Veterans Affairs' (VA) Projected Demand for Long-Term Care**

Key challenge	Description
Addressing workforce shortages	<ul style="list-style-type: none"> <li>VA officials described nationwide shortages of geriatricians and palliative care providers—provider shortages that will affect VA’s ability to provide long-term care services to veterans in the future.</li> <li>VA also faces shortages in other workforce areas such as nursing assistant and health technician positions that have contributed to waiting lists for certain long-term care programs.</li> </ul>
Aligning care geographically	<ul style="list-style-type: none"> <li>VA faces challenges aligning its services (provided or purchased) with where veterans live, including providing care for veterans living in rural areas.</li> </ul>
Meeting needs for specialty care	<ul style="list-style-type: none"> <li>VA faces challenges finding appropriate long-term care settings for veterans with certain specialty care needs such as dementia, behavioral issues, and ventilator care.</li> </ul>

Source: GAO analysis of VA documents and interviews. || GAO-20-284

- Addressing workforce shortages.** According to VA, the agency faces challenges hiring the staff needed to meet veterans’ demand for long-term care, a challenge that is likely to grow as demand for care is projected to increase in coming years. We have previously reported on workforce shortages in key positions—such as nursing assistants and home health aides—that are critical for supporting long-term care programs and affect health care systems beyond VA.<sup>37</sup> Within VA, the Healthcare Analysis and Information Group (HAIG) report found that 80 percent of VA community living centers had, at the time of the report, current vacancies for nursing assistant or health technician positions. These workforce challenges have led to waitlists for some long-term care programs. For example, VA officials told us staffing challenges were the key factor creating a waitlist of 1,780 veterans for the Home-Based Primary Care program.<sup>38</sup> (The HAIG report found 65 percent of VA facilities cited staffing as a barrier to expanding Home-Based Primary Care.) GEC officials recognize these workforce challenges and told us they have developed some workforce strategies such as offering geriatrics training to rural primary care providers through GEC’s Geriatric Scholars Program.<sup>39</sup>

<sup>37</sup>See [GAO-16-718](#).

<sup>38</sup>According to VA officials, this waitlist represents the number of veterans not able to get a program appointment within 30 days as of October 1, 2019, and is a result of staffing and other factors. VA officials also provided data showing a waitlist of 2,892 veterans not able to access long-term care purchased by VA in the community as of October 1, 2019.

<sup>39</sup>GEC, together with VA’s Office of Rural Health and VA’s Offices of Patient Care Services and Strategic Integration, created the VA Geriatric Scholars Program in 2008. VA describes the program as integrating geriatrics into primary care practices through tailored education for professional development.

- **Aligning care geographically.** According to VA, the agency faces challenges aligning its provided or purchased long-term care with where veterans live. VA data show that 2.8 million VA-enrolled veterans lived in rural areas as of 2018, and that veteran populations have shifted to different geographic regions. Providing long-term care in rural areas is a challenge experienced by other health care systems; for example, a report from the Rural Policy Research Institute identified challenges with providing long-term care in rural areas, including “more limited access to services and support” and the “absence of an adequate workforce and infrastructure.”<sup>40</sup> VA officials also told us that veterans moving from one region to another presents demand and capacity challenges. For example, officials told us that veterans have moved away from the Northeast and to the South, and that VA now has too many long-term care beds in the Northeast and too few in the South. VA officials acknowledged the challenge of aligning care with where veterans live and pointed to telehealth, where veterans can receive care remotely, and to Veteran Directed Care program, which provides veterans with a budget to manage their own care, as approaches that could provide care to veterans in rural areas with limited access to VA provided or purchased care. GEC officials have also identified potential strategies to address the issue; for example, GEC’s strategic planning includes a proposal to expand telehealth geriatrics services to reach more veterans, although officials told us this effort is currently unfunded. Further, VA officials from the Office of Policy and Planning said an ongoing market assessment project will provide information that will help VA align its provided and purchased care with where veterans live to better meet veteran needs.<sup>41</sup>
- **Meeting needs for specialty care.** According to VA, the agency faces challenges meeting some specialty care needs for veterans in long-term care. Specifically, it can be difficult to find appropriate long-term care settings for veterans with dementia, behavioral issues, and for veterans requiring a ventilator. Meeting specialty care needs is also a challenge for other health care systems; for example, a 2017 study from the RAND Corporation found that the U.S. health system does not have sufficient capacity to care for a growing number of

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<sup>40</sup>Coburn, Andrew F. and Lundblad, Jennifer P. “Rural Long-Term Services and Supports: A Primer.” *Rural Policy Research Institute*. (November, 2017).

<sup>41</sup>Officials told us this market assessment is expected to be completed by the end of 2020 but that they were not sure when the information from the market assessment would be released to GEC officials for use in long-term care strategic planning.

people with Alzheimer's disease.<sup>42</sup> Challenges in providing this type of care are not new for VA. For example, in 2013 we reported that VA officials told us that while "in certain geographic areas [community living centers] provide certain services that are not available in the community, such as dementia care, behavioral health services, and care for ventilator-dependent residents," in other areas "these specialized services might not be available in a [community living center] and instead might be available at a community nursing home."<sup>43</sup> As previously mentioned, VA has developed some programs to provide specialty care (e.g. VA's Spinal Cord Injury and Disability Care program and the agency's efforts to educate home caregivers on how to better serve veterans with dementia).

While GEC recognizes and has taken some steps to address the challenges it faces in meeting the demand for long-term care, our review of GEC's most recently approved strategic planning document from March 2019 shows that GEC has not established measurable goals for its efforts to address these three key challenges.

- GEC has not established measurable goals for its efforts to address workforce shortages, such as specific staffing targets necessary to address the waitlist for the Home-Based Primary Care program, or defining the number of rural providers it expects to train through the Geriatrics Scholar program.
- GEC has not established measurable goals for its efforts to address the geographic alignment of care, such as specific targets for providing long-term care within the Home Telehealth and Veteran Directed Care programs.
- GEC has not established measurable goals for its efforts to address difficulties meeting veterans' needs for specialty care, such as specific targets for the number of available ventilators or the number of caregivers educated to help veterans with dementia.

According to GAO's body of work on effectively managing performance under the Government Performance and Results Act of 1993 (GPRA), as

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<sup>42</sup> The study defines Alzheimer's disease as a progressive neurodegenerative disorder that leads to cognitive decline, dementia, and premature death. See Liu, Jodi L. Et al. *Assessing the Preparedness of the U.S. Health Care System Infrastructure for an Alzheimer's Treatment* (Santa Monica, CA: RAND Corporation, 2017).

<sup>43</sup> GAO, *VA Nursing Homes: Reporting More Complete Data on Workload and Expenditures Could Enhance Oversight*, [GAO-14-89](#) (Washington, D.C.: Dec. 20, 2013).

enhanced by the GPRA Modernization Act of 2010, federal agencies should clarify and clearly define measurable outcomes for each strategic objective and assess progress towards those goals.<sup>44</sup> VA officials told us that competing priorities, including implementation of the VA MISSION Act of 2018, have affected GEC's ability to effectively address challenges to meeting veterans' long-term care needs.<sup>45</sup> Without measurable goals, however, VA is limited in its ability to better plan for and understand progress towards addressing the challenges it faces meeting veterans' long-term care needs. As VA works to address these challenges, it does so along with other health care systems, and VA has opportunities for leveraging outside experience through VA's Geriatrics and Gerontology Advisory Group. For example, the Advisory Group recently acknowledged workforce challenges and recommended that VA "devise strategies to create incentives and identify and remove barriers" for the recruiting and retaining the health care workforce needed to care for VA's growing geriatric veteran population.

In addition to the key challenges that VA and many other health care systems face, VA has identified, but has not planned to take steps to fully address, challenges at the VAMC level that affect its ability to meet veterans' long-term care needs. Specifically, VA has identified issues with inconsistency in the management of the 14 long-term care programs at the VAMC level that could lead to inefficient and inequitable decisions about long-term care across VA. While VA has identified the steps it can take to address these issues, it has not implemented these steps.

- First, VA identified that VAMCs do not have a consistent approach to managing VA's 14 long-term care programs. GEC officials told us that fragmentation of the long-term care programs within the VAMCs—that is, where programs could be run by one or more departments within the VAMC, for example the Nursing department or the Social Work department at VAMCs where there are not GEC staff—hinders standardization and the ability to get veterans the right care. Similarly, the HAIG report found that VAMCs organize their long-term care programs differently and recommended that to "efficiently, reliably, and equitably serve veterans" VA align GEC programs "at all VISNs and eventually VAMCs nationwide." GEC strategic planning

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<sup>44</sup>GAO, *Managing for Results: Practices for Effective Agency Strategic Reviews*, GAO 15-602 (Washington, D.C.: July 29, 2015).

<sup>45</sup>In June 2018, Congress passed and the President signed into law the VA MISSION Act of 2018, which established a permanent community care program. Pub. L. No. 115-182, 132 Stat. 1393.

documents outline a goal of alignment within the VISNs, and officials said alignment has been established within the VISNs. However, VA officials told us that, as of October 2019, they had not taken action to pursue VAMC-level alignment with a GEC point of contact at each VAMC that could provide consistency across long-term care programs at the VAMC level.

- Second, GEC has developed a tool to improve the consistency with which VAMCs determine the amount of services needed for veterans based on their specific health issues. However, as of October 2019, VA has not required the tool be used in all VAMCs. VA has identified that VAMCs do not have a consistent approach to determining the amount of noninstitutional long-term care services veterans need. VA officials told us that, as of October 2019, VAMCs used different methods to assess the amount of noninstitutional long-term care services veterans need—for example, how many hours of in-home care veterans need. As a result, decisions about the amount of services veterans receive may vary by VAMC. The HAIG report recommended that VA use a standardized approach to ensure the “balance of noninstitutional care programs, program reliability, and equity of resource distribution.” GEC officials said the tool they developed is currently being used by some VAMCs, and they expect VA will require the tool to be used by all VAMCs sometime in the next year. However, VA has not set time frames for this requirement.

One of VA’s performance goals is to provide highly reliable and integrated care and support and excellent customer service. Furthermore, federal internal controls dictate that federal agencies should exercise oversight responsibility, for example by overseeing the remediation of deficiencies as appropriate and providing direction to management on appropriate time frames for correcting these deficiencies.<sup>46</sup> Although VA has identified steps it can take to improve consistency in long-term care programs, according to officials, it has not prioritized their implementation. Without a reliably consistent approach to administering long-term care programs across its VAMCs, VA may not consistently and equitably meet veteran preferences and needs.

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<sup>46</sup> [GAO-14-704G](#)

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## Conclusions

VA currently faces difficult challenges meeting the demand for long-term care. These challenges—such as addressing workforce shortages, aligning care geographically, and meeting specialty care needs—are likely to intensify as veterans' demand for long-term care grows. However, a lack of measurable goals in the strategic planning efforts of VA's GEC, which has the lead responsibility for managing VA's 14 long-term care programs, affects VA's ability to appropriately plan for and understand its progress towards addressing long-term care challenges. In addition to these key challenges, VA has identified, but not yet fully addressed, inconsistencies in the management of the 14 long-term care programs at the VAMC level. These inconsistencies in determining both the best program for veterans and the amount of noninstitutional care veterans need can lead to inefficient and inequitable experiences with VA's long-term care programs.

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## Recommendations for Executive Action

We are making the following three recommendations to VA:

The Secretary of VA should direct GEC leadership to develop measurable goals for its efforts to address key long-term care challenges: workforce shortages, geographic alignment of care, and difficulty meeting veterans' needs for specialty care. (Recommendation 1)

The Secretary of VA should direct GEC leadership to set time frames for and implement a consistent GEC structure at the VAMC level. (Recommendation 2)

The Secretary of VA should direct GEC leadership to set time frames for and implement a VAMC-wide standardization of the tool for assessing the noninstitutional program needs of veterans. (Recommendation 3)

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## Agency Comments

We provided a draft of this report to VA for review and comment. In its comments, reproduced in appendix IV, VA concurred with our three recommendations and identified actions it is taking to implement them. Specifically, VA said that it will: (1) take steps to incorporate measurable goals and defined timelines into its strategies to meet the long-term care challenges; (2) work to establish a time frame for the execution of a uniform GEC structure at the VAMC level; and (3) work to establish a time frame for the execution of a VAMC-wide standardized tool for evaluating non-institutional care needs for veterans. VA also provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of the Department of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at [silass@gao.gov](mailto:silass@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



Sharon M. Silas  
Director, Health Care

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*List of Committees*

The Honorable James M. Inhofe  
Chairman  
Committee on Armed Services  
United States Senate

The Honorable Jack Reed  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Jerry Moran  
Chairman  
Committee on Veterans' Affairs  
United States Senate

The Honorable Jon Tester  
Ranking Member  
Committee on Veterans' Affairs  
United States Senate

The Honorable Adam Smith  
Chairman  
Committee on Armed Services  
House of Representatives

The Honorable Mac Thornberry  
Ranking Member  
Committee on Armed Services  
House of Representatives

The Honorable Mark Takano  
Chairman  
Committee on Veterans' Affairs  
House of Representatives

The Honorable Phil Roe  
Ranking Member  
Committee on Veterans' Affairs  
House of Representatives

# Appendix I: Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Program Descriptions

VA provides or pays for long-term services and supports, or long-term care, for eligible veterans through a range of three institutional and 11 noninstitutional programs. VA covers the full or partial cost of nursing home care for eligible veterans who require skilled nursing home care in an institutional program. Specifically, VA covers the full cost of nursing home care for veterans who need this care for a service-connected disability—which is an injury or disease that was incurred or aggravated while on active duty—and for veterans with service-connected disabilities rated at 70 percent or more.<sup>1</sup> To the extent resources allow, VA may cover this care for certain other veterans, such as former prisoners of war and those awarded the Purple Heart.<sup>2</sup> For all other veterans, VA may cover nursing home care to the extent resources and capacity allow and with the veteran's agreement to share certain costs.<sup>3</sup> (See table 2 for more information about these programs.)

**Table 2: Department of Veterans Affairs' (VA) Institutional Long-Term Care Program Descriptions**

<b>Program</b>	<b>Description</b>
VA Community Living Centers	Provide 24-hour skilled nursing care in VA-owned homes, and may also provide domiciliary care, such as for mental health or substance abuse.
Community Nursing Homes	Provide 24-hour skilled nursing care in public or privately owned homes that VA contracts with to provide this care.
State Veterans Homes	Provide 24-hour skilled nursing care in homes that are owned and operated by states.

<sup>1</sup>This requirement expires on September 30, 2020, and is subject to the availability of appropriations. 38 U.S.C. § 1710A(a).

<sup>2</sup>38 U.S.C. § 1710(a)(2).

<sup>3</sup>38 U.S.C. §§ 1710(a)(3), 1710(f), 1710(g). Certain limitations apply.

**Appendix I: Department of Veterans Affairs’  
(VA) Institutional and Noninstitutional Long-  
Term Care Program Descriptions**

Source: GAO analysis of VA documents. || GAO-20-284

Note: We include three of VA’s 14 Long-Term Services and Supports programs that represent its institutional programs, and for the purposes of this report we refer to these programs as long-term care. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. These programs are not reflected in this table.

In addition, all veterans enrolled in the health care system are eligible for VA’s basic medical benefits package, which covers, among other things, a comprehensive array of medically necessary home- and community-based health services.<sup>4</sup> While a veteran’s priority for care generally determines whether these services are provided at full or partial cost, the VA may not charge a copay for home hospice care and may waive copays for home telehealth services. (See table 3 for more information about these programs.) A veteran’s placement in a particular program may depend on their clinical needs, preferences, and the availability of VA funding and programs.

**Table 3: Department of Veterans Affairs’ (VA) Noninstitutional Long-Term Care Program Descriptions**

<b>Program</b>	<b>Description</b>
Homemaker Home Health Aide	Trained aides come to the home to help veterans with activities of daily living through a VA-contracted organization. Alternatively, the Veteran Directed Care program provides veterans with a budget for care.
Home-Based Primary Care	A health care team, supervised by a VA physician, provides health care services to veterans with complex needs.
Purchased Skilled Home Care	Provides nursing care and other health services by a VA-contracted community-based agency for veterans who live far from VA facilities.
Home Telehealth	Allows physicians or nurses to monitor a veteran’s medical condition remotely and to talk with the veteran to discuss care.
Adult Day Health Care	Provides activities and support for veterans who need help with activities of daily living, who are isolated, or have caregivers in need of relief. This care may be provided in VA, state, or community programs.
Home Hospice Care	Provides comfort care for veterans and family in home, clinic or inpatient settings for veterans with less than 6 months to live.
Home Respite Care	Provides short-term care at home or at an adult day care program when family caregivers need a break.
Community Residential Care	Provides 24-hour care, room and meals in family care homes, assisted living homes or medical foster homes for veterans who cannot live alone because of medical or mental health conditions.
Spinal Cord Injury and Disability Home Care	Care centers provide primary and specialty care for veterans who have spinal cord injuries, and local teams provide care close to veterans’ homes.

<sup>4</sup>38 C.F.R. §§ 17.36(a), 17.38(a)(1)(ix) (2019). Also see U.S. Department of Veterans Affairs, *Federal Benefits for Veterans, Dependents and Survivors* (VA Pamphlet 80-18-01 P94663), 2018 Edition.

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**Appendix I: Department of Veterans Affairs'  
(VA) Institutional and Noninstitutional Long-  
Term Care Program Descriptions**

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Source: GAO analysis of VA documents. || GAO-20-284

Note: We include 11 of VA's 14 Long-Term Services and Supports programs that represent its noninstitutional programs, and for the purposes of this report we refer to these programs as long-term care. For the purposes of this table, we condensed the 3 adult day health program descriptions into one entry. In addition, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support Program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. These programs are not reflected in this table.

# Appendix II: Utilization and Obligations for Department of Veterans Affairs' (VA) Long- Term Care Programs, Fiscal Years 2014 to 2018

**Table 4: Utilization for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2014 through 2018**

Utilization by fiscal year. Institutional programs.

Program	Workload unit	2014	2015	2016	2017	2018	Percentage change 2014 through 2018
VA Community Living Centers	Average daily census	9,464	9,221	9,106	9,044	8,926	-6
Community Nursing Homes	Average daily census	7,771	8,311	8,775	9,251	9,808	26
State Veterans Homes	Average daily census	23,176	25,503	23,788	23,522	23,423	1
<i>Subtotal institutional programs</i>		<i>40,411</i>	<i>41,035</i>	<i>41,670</i>	<i>41,817</i>	<i>42,158</i>	<i>4</i>

**Appendix II: Utilization and Obligations for  
Department of Veterans Affairs' (VA) Long-  
Term Care Programs, Fiscal Years 2014 to  
2018**

Noninstitutional programs (workload units in thousands)

Program	Workload unit	2014	2015	2016	2017	2018	Percentage change 2014 through 2018
Homemaker Home Health Aide	VA clinic stops	8,328	9,999	11,136	12,025	12,306	48
Home-Based Primary Care	VA clinic stops	1,599	1,671	1,755	1,770	1,797	12
Purchased Skilled Home Care	Community care visits	1,691	1,818	1,804	1,473	1,872	11
Home Telehealth	VA clinic stops for one month	1,108	1,111	1,047	988	887	-20
Community Adult Day Health Care	Community care visits	866	903	1,003	987	935	8
VA Adult Day Health Care	VA clinic stops	130	124	138	127	122	-6
State Home Adult Day Health Care	Participant slots	53	10	10	11	11	-78
Home Hospice Care	Community care visits	441	462	472	489	478	9
Home Respite Care	Community care visits	310	326	303	290	278	-11
Community Residential Care	VA clinic stops	117	120	117	112	104	-12
Spinal Cord Injury/Disability Home Care	VA clinic stops	21	20	21	20	20	-2

Source: GAO analysis of VA utilization data. || GAO-20-284

Notes: We include only VA's Long-Term Services and Supports programs in this report. VA's utilization data describes the workload units involved in the delivery of care for each program. For example, institutional program workload units use an average daily census that reflects the average number of veterans for which VA funded nursing home care on any given day during the year, such as a day in a community nursing home. Noninstitutional program workload units include VA clinic stops defined as one patient encounter with a VA health care provider, where an individual patient may have multiple procedures or stops in a single visit or in one day, such as for a Home-Based Primary Care program visit with a VA nurse. These units also include community care visits measured by VA payments for specific codes that describe the purpose of a patient visit, such as a payment for a Home Hospice Care program visit from a community provider. The units for each program may differ. VA officials told us that these data do not include non-veterans and may differ from data included in VA's congressional budget justification for a variety of reasons, including the timing of when they looked at the data, the inclusion of additional data, and that VA used a standard definition of services for all years. In addition to these programs, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration.

**Appendix II: Utilization and Obligations for  
Department of Veterans Affairs' (VA) Long-  
Term Care Programs, Fiscal Years 2014 to  
2018**

**Table 5: Obligations for Department of Veterans Affairs (VA) Long-Term Care Programs, Fiscal Years 2014 through 2018**

Obligations by fiscal year (dollars in millions). Institutional programs.

<b>Program</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>Percentage change 2014 through 2018</b>
VA Community Living Centers	3,314	3,384	3,452	3,535	3,685	11
Community Nursing Homes	714	862	847	912	1,064	49
State Veterans Homes	1,014	1,143	1,112	1,176	1,351	33
<i>Subtotal institutional programs</i>	<i>5,043</i>	<i>5,389</i>	<i>5,412</i>	<i>5,623</i>	<i>6,100</i>	<i>21</i>

Noninstitutional programs.

<b>Program</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>Percentage change 2014 through 2018</b>
Homemaker Home Health Aide	449	763	678	792	939	109
Home-Based Primary Care	652	706	734	772	859	32
Purchased Skilled Home Care	206	319	375	427	545	164
Home Telehealth	228	248	271	272	321	41
Community Adult Day Health Care	62	103	78	76	74	19
VA Adult Day Health Care	14	15	15	17	16	12
State Home Adult Day Health Care	5	1	1	2	2	-59
Home Hospice Care	73	91	88	91	93	28
Home Respite Care	29	36	31	42	43	49
Community Residential Care	49	107	92	81	44	-10
Spinal Cord Injury/ Disability Home Care	10	10	11	10	13	38
<i>Subtotal noninstitutional programs</i>	<i>1,777</i>	<i>2,400</i>	<i>2,374</i>	<i>2,583</i>	<i>2,950</i>	<i>66</i>
<b>Total institutional and noninstitutional programs</b>	<b>6,820</b>	<b>7,789</b>	<b>7,786</b>	<b>8,205</b>	<b>9,050</b>	<b>33</b>

Source: GAO analysis of VA data. || GAO-20-284

Notes: We include only VA's Long-Term Services and Supports programs in this report which represents the majority of VA's obligations for long-term care. VA officials told us that these data do not include non-veterans and may differ from data included in VA's congressional budget justification for a variety of reasons, including the timing of when they looked at the data, the inclusion of additional data, and that VA used a standard definition of services for all years. In addition to these programs, VA may provide stipends or other services to caregivers for veterans who were seriously injured in the line of duty through the Caregiver Support program. Disabled veterans may also be eligible for increased compensation benefits from the Veterans Benefits Administration. If adjusted for inflation, the increase in total obligations for institutional and noninstitutional programs from fiscal year 2014 through fiscal year 2018 would be 25 percent.

# Appendix III: Projected Utilization and Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037

**Table 6: Projected Utilization for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037**

Utilization by fiscal year. Institutional programs.

Program	Workload unit	2017	2022	2027	2032	2037	Percentage change 2017 through 2037
VA Community Living Centers	Average daily census	9,128	8,960	8,967	8,667	8,224	-10
Community Nursing Homes	Average daily census	9,562	12,298	14,761	16,563	17,217	80
<i>Subtotal institutional Programs</i>	<i>Average daily census</i>	<i>18,689</i>	<i>21,259</i>	<i>23,728</i>	<i>25,230</i>	<i>25,440</i>	<i>36</i>

**Appendix III: Projected Utilization and Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037**

Noninstitutional programs (workload units in thousands).

Program	Workload unit	2017	2022	2027	2032	2037	Percentage change 2017 through 2037
Homemaker Home Health Aide	VA clinic stops	10,687	14,827	16,870	19,238	19,650	84
Home-Based Primary Care	VA clinic stops	1,317	1,577	1,795	2,048	2,119	61
Purchased Skilled Home Care	Community care visits	1,596	1,866	1,976	2,081	2,019	27
Home Telehealth	VA clinic stops for one month	1,052	1,111	1,132	1,119	1,085	3
Community Adult Day Health Care	Community care visits	951	1,172	1,314	1,452	1,406	48
VA Adult Day Health Care	VA clinic stops	126	130	140	150	143	13
Home Hospice Care	Community care visits	426	479	488	510	501	18
Home Respite Care	Community care visits	278	359	434	518	541	95
Community Residential Care	VA clinic stops	67	60	52	45	38	-43
Spinal Cord Injury/Disability Home Care	VA clinic stops	20	20	21	21	20	1

Source: GAO analysis of projected VA utilization data. || GAO-20-284

Notes: We include only VA's Long-Term Services and Supports programs that VA projects using its Enrollee Health Care Projection Model, based on 2017 data, and do not include state-owned and operated veterans programs, such as State Veterans Homes. VA's utilization data describes the workload units involved in the delivery of care for each program. For example, institutional program workload units use an average daily census that reflects the average number of veterans for which VA funded nursing home care on any given day during the year, such as a day in a community nursing home. Noninstitutional program workload units include VA clinic stops defined as one patient encounter with a VA health care provider, where an individual patient may have multiple procedures or stops in a single visit or in one day, such as for a Home-Based Primary Care program visit with a VA nurse. These units also include community care visits measured by VA payments for specific codes that describe the purpose of a patient visit, such as a payment for a Home Hospice Care program visit from a community provider. The units for each program may differ. Projected workload units have been adjusted to incorporate assumptions about future long-term care, such as the migration of veterans from institutional to noninstitutional long-term care. VA officials told us that these data do not include non-veterans and may differ from data included in VA's budget request for a variety of reasons, including the timing of when they looked at the data, the inclusion of additional data, and that VA used a standard definition of services for all years.

**Appendix III: Projected Utilization and Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037**

**Table 7: Projected Expenditures for Department of Veterans Affairs' (VA) Long-Term Care Programs, Fiscal Years 2017 through 2037**

Expenditures by fiscal year (dollars in millions). Institutional programs.

Program	2017	2022	2027	2032	2037	Percentage change 2017 through 2037
VA Community Living Centers	3,426	3,761	4,300	4,745	5,133	50
Community Nursing Homes	953	1,336	1,735	2,107	2,370	149
<b>Subtotal Institutional Programs</b>	<b>4,379</b>	<b>5,097</b>	<b>6,035</b>	<b>6,852</b>	<b>7,503</b>	<b>71</b>

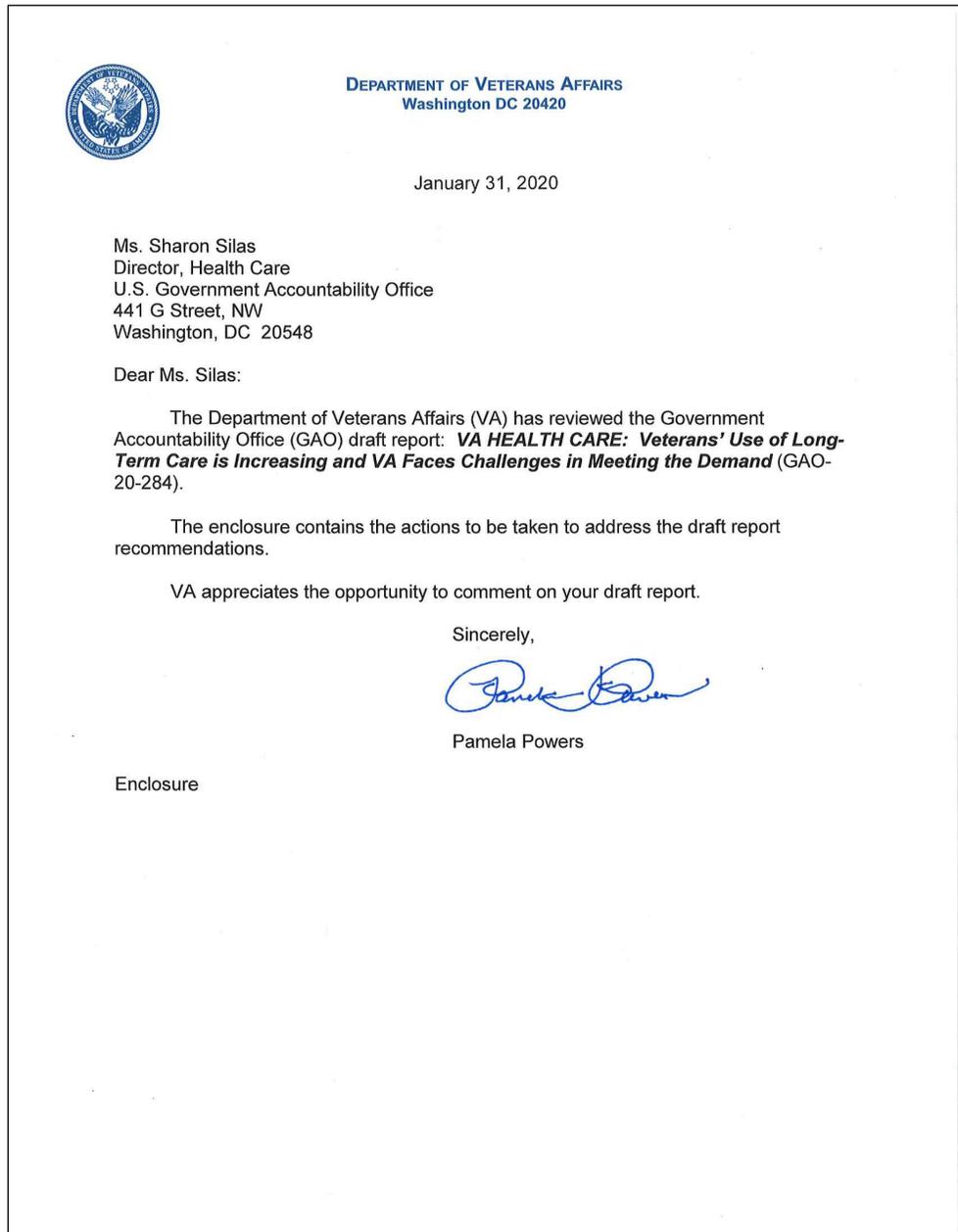
Noninstitutional programs.

Program	2017	2022	2027	2032	2037	Percentage change 2017 through 2037
Homemaker Home Health Aide	746	1,161	1,517	1,986	2,328	212
Home-Based Primary Care	775	1,066	1,419	1,891	2,280	194
Purchased Skilled Home Care	455	596	725	876	976	115
Home Telehealth	225	273	325	376	425	89
Community Adult Day Health Care	86	133	184	248	292	240
VA Adult Day Health Care	17	20	25	31	35	107
Home Hospice Care	97	123	143	172	194	100
Home Respite Care	45	65	91	124	149	231
Community Residential Care	65	67	68	68	67	4
Spinal Cord Injury/Disability Home Care	10	12	14	17	19	84
<i>Subtotal noninstitutional programs</i>	<i>2,521</i>	<i>3,516</i>	<i>4,512</i>	<i>5,789</i>	<i>6,766</i>	<i>168</i>
<b>Total institutional and noninstitutional programs</b>	<b>6,900</b>	<b>8,613</b>	<b>10,547</b>	<b>12,641</b>	<b>14,269</b>	<b>107</b>

Source: GAO analysis of projected VA expenditure data. || GAO-20-284

Notes: We include only VA's Long-Term Services and Supports programs that VA projects using its Enrollee Health Care Projection Model, based on 2017 data, and do not include state-owned and operated veterans programs, such as State Veterans Homes. VA's projected expenditures incorporate assumptions about future inflation and changes in medical care. For example, VA reports that inflation trends account for increases in labor and supply costs, and intensity trends reflect expected changes in the cost mix of services from evolving medical care practices and advances in technology. Part of this increase reflects inflation over time. Using projections from the Congressional Budget Office, for example, prices are expected to rise by 49 percent during the same period. VA officials told us that these data do not include non-veterans and may differ from data included in VA's congressional budget justification for a variety of reasons, including the timing of when they looked at the data, the inclusion of additional data, and that VA used a standard definition of services for all years.

# Appendix IV: Comments from the Department of Veterans Affairs



Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***VA HEALTH CARE: Veterans' Use of Long-Term Care is Increasing and  
VA Faces Challenges in Meeting the Demand***  
(GAO-20-284)

**Recommendation 1: The Secretary of VA should direct GEC leadership to develop measurable goals for its efforts to address key long-term care challenges: workforce shortages, geographic alignment of care, and difficulty meeting veterans' needs for specialty care.**

**VA Comment:** Concur. In collaboration with the VA Office of Healthcare Transformation, the Office of Geriatrics and Extended Care (GEC) completed a 2-day sequester in January 2020, with the following Veterans Health Administrations (VHA) Program Offices: Policy and Planning, Community Care, Nursing, Mental Health, Primary Care, and Care Management/Social Work to identify strategies to include measurable goals and defined timelines to meet the long-term care challenges facing our aging and/or disabled Veteran population. In February 2020, GEC will work in partnership with the VHA program offices and seek concurrence from the Executive in Charge on VHA's strategic approach to meet the long-term care challenges facing our aging and/or disabled Veteran population. Target Completion Date: March 30, 2020.

**Recommendation 2: The Secretary of VA should direct GEC leadership to set time frames for and implement a consistent GEC structure at the VAMC level.**

**VA Comment:** Concur. GEC will work in partnership with the Veterans Integrated Service Networks Directors and the Rehabilitation Extended Care Integrated Community Council to establish a timeframe for the execution of a uniform GEC structure at the VA medical facility level. Target Completion Date: March 30, 2021.

**Recommendation 3: The Secretary of VA should direct GEC leadership to set time frames for and implement a VAMC-wide standardization of the tool for assessing the noninstitutional program needs of veterans.**

**VA Comment:** Concur. GEC will work in partnership with the VA Office of Mental Health to establish a timeframe for the execution of a VA medical facility-wide standardized tool for evaluating non-institutional care needs for Veterans. Target Completion Date: June 30, 2020.

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## Agency Comment Letter

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### Text of Appendix IV: Comments from the Department of Veterans Affairs

#### Page 1

January 31, 2020

Ms. Sharon Silas Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government  
Accountability Office (GAO) draft report: VA HEALTH CARE: Veterans' Use of Long-  
Term Care is Increasing and VA Faces Challenges in Meeting the Demand (GAO-  
20-284).

The enclosure contains the actions to be taken to address the draft report  
recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Pamela Powers  
Enclosure

#### Page 2

### **Department of Veterans Affairs (VA) Comments to Government Accountability Office (GAO) Draft Report.**

### **VA HEALTH CARE: Veterans' Use of Long-Term Care is Increasing and VA Faces Challenges in Meeting the Demand (GAO-20-284)**

#### **Recommendation 1:**

The Secretary of VA should direct GEC leadership to develop measurable goals for  
its efforts to address key long-term care challenges: workforce shortages,

geographic alignment of care, and difficulty meeting veterans' needs for specialty care.

VA Comment: Concur. In collaboration with the VA Office of Healthcare Transformation, the Office of Geriatrics and Extended Care (GEC) completed a 2-day sequester in January 2020, with the following Veterans Health Administrations (VHA) Program Offices: Policy and Planning, Community Care, Nursing, Mental Health, Primary Care, and Care Management/Social Work to identify strategies to include measurable goals and defined timelines to meet the long-term care challenges facing our aging and/or disabled Veteran population. In February 2020, GEC will work in partnership with the VHA program offices and seek concurrence from the Executive in Charge on VHA's strategic approach to meet the long-term care challenges facing our aging and/or disabled Veteran population. Target Completion Date: March 30, 2020.

**Recommendation 2:**

The Secretary of VA should direct GEC leadership to set time frames for and implement a consistent GEC structure at the VAMC level.

VA Comment: Concur. GEC will work in partnership with the Veterans Integrated Service Networks Directors and the Rehabilitation Extended Care Integrated Community Council to establish a timeframe for the execution of a uniform GEC structure at the VA medical facility level. Target Completion Date: March 30, 2021.

**Recommendation 3:**

The Secretary of VA should direct GEC leadership to set time frames for and implement a VAMC-wide standardization of the tool for assessing the noninstitutional program needs of veterans.

VA Comment: Concur. GEC will work in partnership with the VA Office of Mental Health to establish a timeframe for the execution of a VA medical facility-wide standardized tool for evaluating non-institutional care needs for Veterans. Target Completion Date: June 30, 2020.

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# Appendix V: GAO Contact and Staff Acknowledgments

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## GAO Contact

Sharon M. Silas, (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Luke Baron (Analyst-In-Charge), Kye Briesath and Corinne Quinones made key contributions to this report. Also contributing were Laurie Pachter, Vikki Porter, Jennifer Rudisill, and Selah Myers.

# Appendix VI: Accessible Data

## Data Tables

### Data Table Highlights and Figure 4 for VA Projections for Long-Term Care Expenditures, Fiscal Years 2017 through 2037

Obligations (dollars in billions and percentage).

Year	Total amount (dollars in billions and percentage)	Institutional programs	Noninstitutional programs
2017	\$6.9 (100%)	4.4 (63)	2.5 (37)
2022	\$8.6 (100%)	5.1 (59)	3.5 (41)
2027	\$10.5 (100%)	6.0 (57)	4.5 (43)
2032	\$12.6 (100%)	6.9 (54)	5.8 (46)
2037	\$14.3 (100%)	7.5 (53)	6.8 (47)

### Data Tables for Figure 2: Number of Veterans Receiving Long-Term Care, by Various Characteristics, Fiscal Year 2018

	Veterans under age 65	Veterans aged 65 and older
Age	30% (156,506)	70% (370,281)

	Veterans who served on after 9/11	Veterans who served before 9/11
9/11 Service	9% (50,028)	91% (480,299)

	Veterans with service-connected disabilities	Veterans without service-connected disabilities
Service-connected disabilities	55% (291,197)	45% (239,130)

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**Data Table for Figure 3: Obligations for Department of Veterans Affairs' (VA) Institutional and Noninstitutional Long-Term Care Programs, Fiscal Years 2014 through 2018**

Obligations (dollars in billions and percentage).

<b>Year</b>	<b>Total amount (dollars in billions and percentage)</b>	<b>Institutional programs</b>	<b>Noninstitutional programs</b>
2014	\$6.8 (100%)	5.0 (74)	1.8 (26)
2015	\$7.8 (100%)	5.4 (69)	2.4 (31)
2016	\$7.8 (100%)	5.4 (70)	2.4 (30)
2017	\$8.2 (100%)	5.6 (69)	2.6 (31)
2018	\$9.1 (100%)	6.1 (67)	2.9 (33)

## Related GAO Reports

*Veterans Affairs: Sustained Leadership Attention Needed to Address Long-Standing Workforce Problems*, [GAO-19-720T](#) (Washington, D.C.: Sept. 18, 2019).

*Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding*, [GAO-19-670](#) (Washington, D.C.: Sept. 23, 2019).

*VA Health Care: Actions Needed to Improve Family Caregiver Program*, [GAO-19-618](#) (Washington, D.C.: Sept. 16, 2019).

*Veterans Health Care: Opportunities Remain to Improve Appointment Scheduling within VA and through Community Care*, [GAO-19-687T](#) (Washington, D.C.: July 24, 2019).

*VA Health Care: Estimating Resources Needed to Provide Community Care*, [GAO-19-478](#) (Washington, D.C.: June 12, 2019).

*VA Real Property: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations*, [GAO-19-440](#) (Washington, D.C.: June 13, 2019).

*VA Nursing Home Care: VA Has Opportunities to Enhance Its Oversight and Provide More Comprehensive Information on Its Website*, [GAO-19-428](#) (Washington, D.C.: July 3, 2019).

*Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers*, [GAO-16-718](#) (Washington, D.C.: Aug. 16, 2016).

*VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, [GAO-16-24](#) (Washington, D.C.: Oct. 28, 2015).

*VA Nursing Homes: Reporting More Complete Data on Workload and Expenditures Could Enhance Oversight*, [GAO-14-89](#) (Washington, D.C.: Dec. 20, 2013).

*Older Americans: Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk*, [GAO-10-611](#) (Washington, D.C.: June 21, 2010).

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**Related GAO Reports**

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*VA Health Care: Long-term Care Strategic Planning and Budgeting Need Improvement*, [GAO-09-145](#) (Washington, D.C.: Jan. 23, 2009).

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