LEGISLATIVE HEARING ON 'DRAFT LEGISLATION, THE LONG–TERM CARE VETERANS CHOICE ACT'; H.R. 1443; H.R. 1612; H.R. 1702; H.R. 2065

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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LEGISLATIVE HEARING ON 'DRAFT LEGISLATION, THE LONG–TERM CARE VETERANS CHOICE ACT'; H.R. 1443; H.R. 1612; H.R. 1702; H.R. 2065

Tuesday, July 9, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:08 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Brownley, Ruiz, Kuster.

Also Present: Representative Miller.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Good morning. The Subcommittee will come to order.

Thank you all for joining us this morning to discuss pieces of legislation concerning health care and services available to the Department of Veterans Affairs' VA health care system.

The five bills that we will discuss today are draft legislation, the Long-Term Care Veterans Choice Act; H.R. 1443, the Tinnitus Research and Treatment Act of 2013; H.R. 1612, to direct the secretary of Veterans Affairs to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University; H.R. 1702, the Veterans Transportation Service Act; and H.R. 2065, the Safe Housing for Homeless Veterans Act.

From ensuring the safety of homeless veterans residing in VA homeless grant and per diem facilities to ensuring that veterans eligible for VA-paid nursing home care are able to receive care in certified medical foster homes should they choose, these five bills address a number of critical issues facing today's veterans and all of us charged with caring for them.

I am eager to discuss each of these proposals in depth to ensure a thorough understanding of their purpose, intended benefits, and unintended consequences.

I am grateful to my colleagues who sponsored these bills and to our witnesses for being here to discuss them with us. I look forward to our conversation.

With that, I now yield to Ranking Member Brownley for any opening statement she may have.

[THE PREPARED STATEMENT OF HON. BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman.

And we do have five important bills here today and look forward to the discussion. And to allow maximum time for that discussion, I will limit my opening remarks primarily to H.R. 1443 and H.R. 1702.

H.R. 1443, the Tinnitus Research and Treatment Act of 2013, as offered by Ranking Member Michaud, according to the VA, tinnitus is the number one service-connected disability for veterans from all periods of service affecting over 840,000 veterans.

Since 2005, the number of veterans receiving service-connected disability for tinnitus has increased by at least 15 percent each year and the VA has been paying out over $1.2 billion annually to veterans for tinnitus disability compensation.

At the current rate of increase, service-connected disability payments to veterans for tinnitus will cost $2.26 billion annually by 2014. Nevertheless only about $10 million is dedicated to researching tinnitus in the public and private sectors.

H.R. 1443 will allow for appropriate research time and resources by directing the VA to recognize tinnitus as a mandatory condition for research and treatment by the VA auditory centers for excellence.

This will make certain that research is conducted at the VA facilities on the prevention and treatment of this condition and that the VA cooperates with the Department of Defense's hearing center of excellence to further research on tinnitus.

H.R. 1443 would ensure that we remain on the cutting edge for research and treatment of this issue facing veterans of all ages.

Next, H.R. 1702, introduced by Mr. Barber of Arizona, would permanently authorize the VA to operate the Veterans Transportation Service which provides transportation for individuals to and from the VA medical facilities in connection with vocational rehabilitation, counseling, examination, treatment, or care.

VTS was launched in 2010 and the VA's current authority to operate the program is set to expire in January of next year. I did want to emphasize the critical need for this legislation in helping to increase access to care for those who would otherwise face challenges in getting to and from their appointments at the VA.

I also wanted to highlight that VA has estimated VTS to save up to $19.2 million in fiscal year 2014 and $102.7 million over five years because it is less expensive for the VA to hire drivers through VTS than to contract with ambulance services or to provide mileage reimbursement. So this is simply a common-sense initiative.

Thank you, Mr. Chairman, for including these bills in the agenda and I look forward to hearing the views of our witnesses on the legislation before us today. And I yield back my time.

[THE PREPARED STATEMENT OF HON. BROWNLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you.

The Chairman of the Full Committee, Jeff Miller from Florida's 1st Congressional District, will be joining us later this morning to

discuss his draft legislation, the Long-Term Care Veterans Choice Act. I will yield to him when he arrives.

In the meantime, it is an honor to be joined by my friends and colleagues, Mike Rogers, Representative from Alabama's 3rd Congressional District, and David McKinley, Representative from West Virginia's 1st Congressional District.

Thank you for your leadership on behalf of our veterans and for being with us this morning to discuss your proposals. It is an honor and pleasure to have you here this morning.

I would like to mention for the record that Mr. Barber will not be with us today due to the tragic circumstances that have taken place in Arizona and our thoughts and prayers are with the families of the first responders there who have perished. Their loved ones are true heroes and their sacrifice will never be forgotten.

Mike, we will begin with you. Please proceed with your testimony. You have five minutes.

STATEMENTS OF HON. MIKE ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA; HON. DAVID MCKINLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

STATEMENT OF HON. MIKE ROGERS

Mr. ROGERS. Thank you, Mr. Chairman and Ranking Member Brownley.

First I want to thank the Chairman and the staff for holding this hearing. I also want to thank the Full Committee Chairman, Jeff Miller, for his leadership on behalf of our Nation's veterans.

Mr. Chairman, H.R. 1612 will benefit the Department of Veterans Affairs and the people of Tuskegee, Alabama.

In 1922, the Board of Tuskegee University voted to donate 300 acres of land to the Federal Government for a veterans' hospital. Since that time, Tuskegee VA Hospital and Tuskegee University have grown into integral parts of the community and serve important roles for our Nation.

Now as the VA refocuses its mission to better serve our veterans, some of the donated land near the university's campus no longer fits the VA's needs.

My bill would transfer back 64.5 acres of land at 2400 Hospital Road back to Tuskegee University so that the land can better serve the community.

This transfer also creates new opportunities for the VA by reducing substantial overhead and maintenance costs and providing cooperative authority to leverage the strengths of both institutions.

This bill is supported by the VFW, the Vietnam Veterans of America. Both organizations know well Tuskegee's place in our history and I appreciate their continued support for the community.

I thank you again, Mr. Chairman and Ranking Member Brownley. And with that, I will yield back.

[THE PREPARED STATEMENT OF HON. ROGERS APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much.

David.

STATEMENT OF HON. DAVID MCKINLEY

Mr. MCKINLEY. Thank you, Mr. Chairman.

Ranking Member Brownley and the rest of you on the Subcommittee, thank you for holding this hearing. I appreciate the opportunity to give these remarks about H.R. 2065 called the Safe Housing for Homeless Veterans Act.

This is the same bill that we passed last year, slightly modified, but it is essentially the same bill for the homeless veterans.

Currently, there are over 2,100 community-based homeless veteran service providers across the country and many other homeless assistance programs that have all demonstrated an effort to try to take care of our homeless veterans.

I visited some of these shelters throughout West Virginia, not only in my district, but elsewhere.

You have to understand my background. I come from the construction industry. I am one of two licensed engineers in Washington, in Congress. So it does not take me long to walk into a building and I can tell you whether or not that building meets code.

And when I walked into some of these shelters, I was appalled with what we have done to our veterans. They have been in harm's way and they come back and their lives are challenged in some of these facilities.

There is no current law. There is a policy within the VA to comply with building codes. Think about that. It is a policy, not a requirement. It is a policy. I think this is an omission governing our veterans' homeless program funds.

H.R. 2065 would require that any organization that seeks funding from VA for services to homeless veterans have documentation that their building meets or exceeds building code. Not a policy. It shall. These men and women sacrificed for our country, they must have a safe home.

This bill makes it easier for facilities to be certified as we open up these requirements beyond just the life safety code, which is 101, NFPA–101, to international building code and the fire codes and other versions of these codes.

Essentially what the local jurisdiction has adopted, work with them, but make it a requirement, not a policy.

Furthermore, the legislation would require adding a section to VA annual report to Congress that would report the number of grant recipients or eligible entities who have submitted a certification, that their facility will meet all building codes.

I understand there is some concern over the undue burden for these facilities, but as you will see in the questions, I will be able to expound a little bit further about that, that is not quite accurate. When you travel, do your research in other facilities around the country, annual inspections are expected and demanded. And it is not an undue burden.

In West Virginia, it is at no cost to the facility provider to have an inspection done to see that you are in compliance.

I am pleased. I want you to know that we have already begun our discussions with those individuals that may have some concerns with this, particularly the VA and others, that may have a concern that we are undue burden.

Quite frankly, Mr. Chairman, I am more interested in the veterans than I am about bureaucracy. If we are going to put these men and women in harm's way, I want to take care of the problem. And if it costs us $100 a year to have an inspection, then that is the least of my concerns.

These men and women deserve to have a focus for them so that when they come home and they have, for whatever the circumstances are that they have to live in a homeless shelter, they should feel comfortable that they are going to wake up in the morning and there is not going to be a catastrophe wrapping around them.

So with that, I will yield back my time and hope that we have an opportunity to have further discussion and I hope you will be able to support this effort to take care of our homeless veterans. Thanks you.

[THE PREPARED STATEMENT OF HON. MCKINLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. McKinley.

I will now yield to Ms. Brownley who will provide testimony on H.R. 1443. No?

Ms. BROWNLEY. No.

Mr. BENISHEK. Well, I think that I will proceed with the questions. And I will start out.

Mr. Rogers, what is the key benefit for this piece of legislation?

Mr. ROGERS. Well, it is twofold. The university needs the land back for its expansion, but more importantly the VA does not need it and it has just been a maintenance burden for them financially.

There is a large part of their campus that has not been used for years. It is deteriorating. They are going to have to spend money to either bring those buildings back or at least make them safe or tear them down. And they do not really want to do either.

Mr. BENISHEK. So there are some unused buildings there?

Mr. ROGERS. That is exactly what it is, as well as land.

Mr. BENISHEK. Does the university have plans to do something right away with the land?

Mr. ROGERS. Not right away, but they would like to use it for long-term plans.

Mr. BENISHEK. All right. Thank you.

Mr. McKinley, I appreciate your continued advocacy on this issue and I completely agree with the need for safe shelters.

Can you comment on the scope of the problem and tell me what you see as the lack of VA oversight?

Mr. MCKINLEY. Thank you.

I do not want to speak necessarily for the VA. I think they can speak for themselves. But it is my understanding that there is an effort. They think they are handling these issues internally. They may believe that.

But, again, my training, and I started in construction in 1965. Think about that, the age. That gives me away a little bit, doesn't it, Ms. Brownley?

But it does not take me long to understand there is a violation. And if they, Chairman, have that knowledge, then why didn't they correct it?

Example could be down in Atlanta. We have from the Joint Commission this report in Atlanta that says the Atlanta Medical Center was supposed to take care of their facility, that they have violations that are listed on page nine, insufficient compliance on meeting the requirements under the NFPA–101. 101 is life safety.

Under the door category, insufficient compliance, space around pipes, conduit where fire and smoke and gases, insufficient compliance. I could go on. But here it is a facility that should have the knowledge and they are not fulfilling that.

We have examples around the country of fires.

Mr. BENISHEK. May I ask a question?

Mr. MCKINLEY. Five people were killed in a Texas shelter.

Mr. BENISHEK. Mr. McKinley, let me ask you this question.

Mr. MCKINLEY. I could go on. There are just examples like that, Mr. Chairman—of examples where people have not followed the code. They do a wink and a nod. But there are people that are dying every day and there is needless deaths that are occurring or harm coming to individuals because they are not following the building code.

Mr. BENISHEK. Can you give me a couple examples of the things that you saw yourself when you were there? You mentioned that you are an engineer and you noticed some things right away. What were some of the things that you noticed?

Mr. MCKINLEY. I have seen lack of sprinkler systems and I know that if you are going to have a combined-use where you have counseling and housing, there is a requirement to have a fire separation, a two-hour separation, as well as sprinkler systems required by 101. Not what is happening time and time again.

You are fortunate if you get an alarm system. I saw doors that are not rated. When I mean rated doors, you can have ratings that maybe have to be as long as two hours before the door will burn. I can tell you these doors are not rated because on the inside panel on the door, there is a chip that is affixed. They have a label and it will tell you whether it is rated. I went through, I do not know how many facilities and I have looked for those labels and they are not there.

We see fire exit ways. They are supposed to be lit. There are strobe lights that were not there at these facilities.

These people, Mr. Chairman, are trying to help out the veterans, but in so doing they are cutting corners. And I just want them to comply with the standards. This is not going to cost the VA one additional dollar. But the owners of these facilities are going to have to have proper compliance with the code, not a wink and a nod, so our men and women are safe when they go to bed at night.

Mr. BENISHEK. Thank you.

Ranking Member Brownley, do you have any questions?

Ms. BROWNLEY. No.

Mr. BENISHEK. Dr. Ruiz.

Mr. RUIZ. Thank you both for your work and your support for veterans.

I have a question for you, Honorable McKinley. The veterans, do we now have a sense of how many go to veteran-specific shelters versus general homeless shelters?

Mr. MCKINLEY. That is a fair question. No, I do not know. It is just a troubling statistic that anyone winds up in a homeless shelter.

But when I have talked to some of them that are there, keeping it certainly anonymous to keep their identify, just for whatever has happened, whether it can be they are having post-traumatic, they cannot keep a job, they have lost their family life because of their issues, series of issues. Unfortunately, they are there.

The VAs do not have the bed capacity to be able to keep them there, so they are providing space for them here at, I guess, a per diem basis for them to be able to stay at these facilities.

So I do not know how many would be there in a VA sponsored versus one that might be just a non-veterans' homeless shelter. But I can tell you, Congressman, I am seeing the problems in both. It is not just the VAs. The VAs, I think, want to do what is right, but they want to use a policy.

I think we ought to make it statutory so that it does not vary from state to state to state and municipality where there is a wink and a nod that they will let them stay there. Let's give people ability to have safe housing whether they are in a public one or in a VA sponsored facility.

Mr. RUIZ. And that is the point of my question was to figure out if—you know, our primary concern with this bill is to make sure that veterans themselves have a safe place to rest given the special covenant that we have with our veterans. And in general, we should strive to make sure that any homeless could have a safe place to stay at night as well.

But in this special case, if the majority go to private or non-profit shelters, which is usually the case, the non-profit organizations, then my concern is are we still reaching out to those homeless shelters for them so they can have their place to sleep?

Mr. MCKINLEY. In my jurisdiction, in the 1st district of West Virginia, whenever I see one of these in a non-VA related facility, I talk to the municipality about whether or not to make them in compliance.

Mr. RUIZ. Okay.

Mr. MCKINLEY. But we do not have jurisdiction over those facilities. We have the jurisdiction where there is Federal money being used to help these individuals. That is why I am dealing with it here, but I am dealing with the other in another matter. And it has to be done on a case by case, municipality by municipality.

Mr. RUIZ. Thank you very much.

Mr. MCKINLEY. Thank you.

Mr. BENISHEK. Ms. Kuster, you have any questions?

Ms. KUSTER. Just briefly. Thank you very much.

Thank you very much for your testimony and for bringing these bills forward. And I just want to address a question to Mr. McKinley.

And you seem well-versed in this, so I just want to understand. I have worked in the past in my State of New Hampshire with colleges and universities in dormitories and housing and trying to comply with local codes. And I know that there is a distinction between the international building and fire codes and the life safety codes.

Mr. MCKINLEY. Yes.

Ms. KUSTER. And I am just wondering what the impact—I agree with your intent and I want homeless veterans to be in safe conditions.

In New Hampshire, the facilities that I have seen have been very safe. But my concern is not to add to the burden and have an unintended consequence of inadvertently making housing less available to homeless veterans.

So if you could comment on how this will work with the international code, the life safety code, and that there is local approvals that might be required.

Mr. MCKINLEY. Let me see. I will try to answer that.

Ms. KUSTER. For the layperson.

Mr. MCKINLEY. We took some time yesterday and I think it also began on Friday trying to contact some other states to find out how they deal with these shelters because if the concern is over the $100 or whatever the cost, $200, if that is going to be a burden.

Ms. KUSTER. We can deal with it.

Mr. MCKINLEY. Think about it. Think about that.

Ms. KUSTER. Yes.

Mr. MCKINLEY. An annual cost of $100 spread out over your facility or $200. We found out again in West Virginia, those inspections to see that they are in compliance are done at no cost. In Virginia, they have an annual state requirement that no one is complaining about in Virginia.

In New York, there is an annual local level for all publicly accessed buildings and Utah performs the same thing, fire safety. In fact, in Utah, they have to fill out this 60-page document every year to give everyone a comfort level that the buildings are safe and that we can put human occupants in that building and they can walk out the next day.

So I think the little bit of burden of having to do paperwork once a year, I think, is certainly appropriate given that we are putting people that are hurting emotionally to give them the comfort that their living conditions and their environment, that they will be safe.

And I think we will find if we continue doing the research, we will find that all across America there are those requirements either to comply with life safety, the 101 and the National Fire Protection Agency or some of these other codes, the ICC which is generally observed for most of the states around the country, but I think every state has to comply with the NFPA–101.

Ms. KUSTER. Good. Thank you.

Mr. MCKINLEY. That is what we are asking for here. Do not make it a policy.

Ms. KUSTER. Uh-huh.

Mr. MCKINLEY. Make it a requirement when they get their license every year and it may not cost anything depending upon your state.

Ms. KUSTER. Okay. Thank you very much.

I yield back.

Mr. BENISHEK. Mr. Huelskamp, do you have any questions?

Mr. HUELSKAMP. No thanks.

Mr. BENISHEK. Well, thank you. Thank you again for coming. Since there are no further questions, the first panel is now excused.

I welcome our second panel to the witness table. Joining us on the second panel is Mr. Jacob Gadd, the Deputy Director for Health Care for the Veterans Affairs and Rehabilitation Division in The American Legion; Dr. Susan Shore, Chair of the Scientific Advisory Committee for the American Tinnitus Association; Mr. Adrian Atizado, the Assistant National Legislative Director for the Disabled American Veterans; Robert Drexler, member of the Board of Directors for the International Code Council; and Mr. Raymond Kelley, the Director of the National Legislative Service for the Veterans of Foreign Wars.

Thank you all for being here this morning and for your hard work and advocacy for our veterans. I appreciate you coming here to present your views of your members and I anticipate your testimony with eagerness.

We will begin with Mr. Gadd. Please begin your testimony. You have five minutes.

STATEMENTS OF JACOB B. GADD, DEPUTY DIRECTOR FOR HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION; SUSAN E. SHORE, CHAIR, SCIENTIFIC ADVISORY COMMITTEE, AMERICAN TINNITUS ASSOCIATION; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; ROBERT DREXLER, MEMBER, BOARD OF DIRECTORS, INTERNATIONAL CODE COUNCIL; RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

STATEMENT OF JACOB B. GADD

Mr. GADD. On behalf of the 2.4 million members of The American Legion, I would like to thank you, Chairman Benishek, Ranking Member Brownley, and Members of the Committee, for the opportunity to provide comments on these health care bills.

H.R. 1702 is needed to ensure that Veterans Transportation Service program is authorized as a permanent authority. For years, VA transportation programs and initiatives have been viewed as an ancillary or secondary service area, but The American Legion recognizes that veterans' transportation programs are vital and often the difference between whether a veteran is seen for care or not.

VTS originated as a VA transformation initiative to ensure veterans with serious injury, illness, and those who live in remote areas receive travel.

In May 2012, VA general counsel rendered an opinion which found that VA only has the authority to use volunteer drivers to provide veterans transportation to and from VA health facilities, not paid employees.

The American Legion became involved after the general counsel ruling as we had just finished up our system worth saving report on rural health care.

In this report, we visited VA medical centers and hosted town hall meetings with veterans to understand firsthand what chal-

lenges veterans face in highly remote areas such as in Maine, Kansas, Missouri, New Mexico, and Wyoming.

We found that for many veterans driving long distances were a disincentive and barrier to them receiving care. We found that VTS was a viable solution as it offered veterans a secondary option to supplement current VA transportation programs.

We found concerns with VA's current organizational structure of transportation programs in VA medical facilities which is fragmented and disjointed with different transportation programs located throughout the hospital instead of in one central place.

Based on the findings of the report and in response to VA's general counsel ruling, The American Legion adopted Resolution 293, the veterans transportation system and benefits travel. This resolution urged VA to establish a transportation department within each VA medical center to coordinate and oversee all transportation programs in the hospitals such as conducting transportation catchment analysis, Veterans Transportation Service program initiatives, volunteer transportation drivers, beneficiary travel programs, and valet programs.

As one veteran recently told us in Nevada, veterans travel as far as 200 miles to the VA medical center for required appointments as the service is not available in their CBOCs.

These van pools require them to leave their residence very early in the morning and not return home until later in the day. Due to medical conditions, not all veterans can withstand this type of travel and instead take their personal vehicles. A number of these veterans are subjected to a fixed budget and often find the cost of travel for medical care a rather large burden.

Veterans have a choice where they want to receive their health care. If their transportation needs are not met or fulfilled by VA, they may not receive care at VA or worse not receive care at all.

The American Legion supports this legislation but urges this Committee to include provisions requiring the VA to establish veterans' transportation departments within VA medical centers to maximize coordination, efficiency, and availability of transportation options for veterans.

Regarding draft legislation on the Long-Term Care of Veterans Choice Act, while The American Legion does not have an official position on medical foster programs, we have noted VA's trend in several years of reducing institutional care beds in lieu of other community options.

American Legion Resolution 121 has three actions that we stated VA be required by the 1998 Millennium Health Care Act to maintain and restore its in-house nursing home capacity to 13,391 beds; second that VA create incentives and receive appropriate funding to maintain its nursing home beds rather than abandon them to alternative sources; third that Congress appropriate sufficient funds to support the provisions of the Millennium Health Care Act so VA is not forced to reduce its nursing home care unit capacity.

Understanding that not every veteran requires long-term care or skilled nursing in an institutionalized setting, it is important to The American Legion and America's veterans that the availability is there if the need in the VA exists, particularly as the number

of World War II veterans and Vietnam veterans needing skilled care is poised to increase over the coming years.

Now is not the time to be reducing capacity or availability of long-term care. The consequence of not having availability of long-term beds is that state veterans' homes and other non-VA long-term care options will be overtaxed and unable to admit veteran patients.

Once again, American Legion thanks you for this opportunity to testify on these important bills today.

[THE PREPARED STATEMENT OF JACOB B. GADD APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much. I appreciate your testimony.

Dr. Shore, why don't you please start.

STATEMENT OF SUSAN E. SHORE

Ms. SHORE. Good morning. Thank you for this opportunity to give testimony on H.R. 1443, the Tinnitus Research and Treatment Act of 2013.

Good morning, Chairman Benishek and Ranking Member Brownley and the rest of the distinguished Members of the Health Subcommittee.

My name is Dr. Susan Shore and I am the chair of the Scientific Advisory Board for the American Tinnitus Association often called ATA.

This is a very important issue, the issue of tinnitus sometimes pronounced tinnitus, and it is especially important because it is often ignored as it is viewed as an invisible disorder, an invisible disorder because nobody but the people who are suffering from it know that it is there. It is a subjective phenomenon.

And because of this, I think this is one of the reasons that it is underfunded. So on behalf of the ATA and the 50 million Americans afflicted with tinnitus, I am going to give you some background on why I think it is so important to get more money for research.

So the ATA funds research grants and it is the only member-based and non-profit organization dedicated to finding a cure for tinnitus in the United States. Since 1980, we funded grants towards better understanding of the mechanisms that are responsible and underlying the genesis of tinnitus.

The advances in tinnitus research over the past decade have been extraordinary. One of the most important advances has been the ability to visualize tinnitus through the use of advanced functional imaging technologies and also through the development of animal models that can behaviorally assess the presence of tinnitus in animals. These methods allow us to pinpoint tinnitus to certain regions of the brain.

Another important advancement that has occurred mostly through the use of animal models is the discovery that tinnitus is a result of brain plasticity or disorganization of the brain. And these developments have led the scientific community to understand that tinnitus is a disorder of brain function and not a dis-

order of the ear that has been the common misconception for decades.

So while noise overexposure is still the number one cause of tinnitus, it can also develop in the absence of hearing loss and absence of hearing damage and because of the result of head and neck injury.

Tinnitus is the number one service-connected disability for returning veterans from Iraq and Afghanistan and elsewhere and as mentioned in the introduction, tinnitus in these veterans is most often the result of extreme noise exposure from either a single impulse or the accumulation of noise exposures.

However, head and neck injuries are also a leading complaint of these veterans. In fact, lumbosacral and cervical strain account for 23 percent of service-connected disabilities for Iraq and Afghanistan veterans.

And so in addition to these factors that cause hearing loss, there are other factors that result from somatic insults including lumbosacral and cervical strain.

Research into how these systems interact in the brain has the potential to lead to treatment such as tailored devices that aim to ameliorate the aberrant brain circuitries resulting from both a combination of hearing loss and head and neck injuries.

When you consider the costs that have already been mentioned for disabilities and in comparison to what is being spent on tinnitus research in the U.S., there is a severe disconnect.

Up until very recently, the amount of money being spent on tinnitus research has been negligible and amounts to about $10 million most recently which is up from $5 million in 2005, but still it is not nearly enough to address a disorder that affects so many millions of people.

I would like to just quickly address the current treatments that are offered in the VA. And while we applaud the efforts of the VA, current treatments that are offered as part of the progressive tinnitus management program, while applaudable are not addressing issues that have been highlighted through research.

For example, they use sound therapy as their only treatment which is not effective for many patients. And so because of this, this is why expanded research is necessary to move forward and use the discoveries that are being made throughout the United States in laboratories as we speak.

So I would like to urge you to passage this legislation and this important one, H.R. 1443. This will go a long way to helping us achieve our goals of improving tinnitus treatment and ultimately finding a cure for this disorder.

Thank you.

[THE PREPARED STATEMENT OF SUSAN E. SHORE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony. I really appreciate it.

Mr. Atizado, I think you are up next.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Thank you, Chairman.

Ranking Member Brownley, Members of the Subcommittee, on behalf of DAV and our 1.2 million members who are wounded and injured veterans, I am pleased to provide our views on the legislation that is on today's agenda.

I would like to highlight two bills to the Subcommittee, the first of which is H.R. 1702. This bill would provide VA a renewed and permanent authority to transport individuals in connection with receiving VA benefits and services.

As mentioned earlier, previously enacted law prompted VA to initiate the Veterans Transportation Service or VTS which were it not for the expiration of its one-year statutory authority would have extended to all VA locations by 2015.

Now, DAV believes VTS can be an ideal partner with our transportation network, the DAV transportation network or DAVTN. While the DAVTN continues to show tremendous growth as an indispensable resource for veterans, VTS serves a special subset of the veteran patient population, one which our transportation network is unable to serve. And that deals specifically with veterans in need of special mode of transportation because of certain aspects of their conditions.

We believe that with a truly collaborative relationship that DAVTN and VTS will meet the growing transportation needs of ill and injured veterans in a cost-effective manner.

Now, as this Subcommittee may be aware, VTS operates on funds that would otherwise go directly to medical care for veterans. Thus, our current support for this bill is based on the progress gained through our working relationship with VA to resolve weaknesses that we have observed with VTS.

Like VA, we want to ensure VTS will indeed work in concert with all existing and emerging transportation resources for veterans who need VA care and to guard against fraud, waste, and abuse of these limited resources.

The second bill is the Long-Term Care Veterans Choice Act which we support based on our national resolution calling for legislation to expand VA's long-term services and supports for service-connected disabled veterans.

Established in 2000 and operating under the same authority as VA's community residential care program, VA's medical foster home approves a private home and the caregiver to care for no more than three veteran residents in any one location.

Caregiver support is provided by the medical foster home attendant. They are provided training and it is required that these attendants have a secondary respite option.

Medical care under the medical foster home is supervised through VA's home-based primary care program or VA's spinal cord injury home care program. Patient participation in this program is voluntary and veteran residents report very high satisfaction ratings.

A lot of veterans that we hear from who would like to go in a medical foster home are not able to do so simply because veterans must pay out of pocket for both room, board, as well as caregiver services. And that amount ranges anywhere from $1,500 to $4,000 a month.

Even veterans who are otherwise entitled to the more costly long-term nursing home care paid fully for by VA either by law or policy cannot get in because they have no means to pay.

DAV is pleased with VA's innovation by offering the medical foster home program as one part of its long-term services and support portfolio and we applaud the intent of this draft legislation to give VA the authority to enter into agreement or contract with a VA approved medical foster home as well as pay for the room, board, and caregiver services.

Mr. Chairman, DAV believes favorable consideration of this draft bill is a good first step for this Subcommittee to ensure veterans have access to a full array of home and community-based long-term services and supports.

Oversight by this Subcommittee is sorely needed as VA endeavors to shift more of its resources away from nursing home care in order to serve more veterans in a cost-effective manner while honoring their preferences in how they live the rest of their lives in light of their impairments.

We urge this Subcommittee to ensure VA innovations and home and community-based services are not stifled and that VA's long-term services and supports provide the broadest array of assistance as possible regardless of age to those veterans who have lost the ability to function or maintain independence in their community.

Mr. Chairman, we look forward to working with the Subcommittee on these two bills and for its passage. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

Thank you.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Atizado.

Mr. Drexler, your testimony, please.

STATEMENT OF ROBERT DREXLER

Mr. DREXLER. Good morning, Mr. Chair and Members of the Subcommittee. My name is Rob Drexler, member of the Board of Directors for the International Code Council. I also serve as Fire Marshal for the town of Greece in New York.

With 26 years in the building and fire code profession and have participated in both the NFPA and ICC code development process, I am pleased to be here today to discuss the importance of compliance with building and fire codes, speaking on behalf of over 50,000 building and fire code officials and other professionals across the United States who are the members of the code council.

The code council was formed in 1994 as a non-profit organization dedicated to developing a single set of comprehensive and coordinated national model construction codes.

The founders of the ICC were BOCA, ICBO, and SBCCI. We joined these three groups together and published a single code for the United States called the international codes.

In 2003, the International Code Council became the successor organization to the three legacy code groups. We now celebrate our tenth anniversary.

Today our international model codes have been adopted at the state or local level in all 50 states and the District of Columbia. Numerous Federal agencies including General Service Administration, the Department of Defense, and the Architect of Capitol have implemented the I codes as have Puerto Rico and the U.S. Virgin Islands.

The code council's 50,000 members and over 300 chapters include state, county, municipal code enforcement, fire officials, architects, engineers, builders, contractors, elected officials, manufacturers, and other construction industry professionals.

I come before you today to encourage support of H.R. 2065, the Safe Housing for Homeless Veterans Act, sponsored by Representative David McKinley of West Virginia and Representative Grace Napolitano of California.

Those of us who work to achieve building safety at both the state and local level appreciate the concern that this bill has for the welfare of our veterans who are living in housing subsidized by the Department of Veterans Affairs.

In the building sector, the IRC, the IBC, and the IFC established basic requirements for building safety at the time of construction and in the case of the fire code at the time of annual inspections.

The codes assure that when faced with hazards including fire, windstorm, flooding, and normal or daily use, the building will allow for residents and users to survive and the first responders to safely rescue building occupants and minimize property damage.

Around the country either at the state or at the local level, both the IBC and the IFC assure that buildings used for residential care and housing are safe. Local code officials around the country inspect veterans' homes and assure that they meet current code requirements just as they do with any other building within their community.

Michigan as well as 42 other states have adopted both the IBC and the IFC. In fact, all 50 states have adopted the IBC while a significant number also adopt the life safety code which is the LSC.

H.R. 2065 wisely does not attempt to mandate one code or the other for compliance in facilities approved by the Department of Veterans Affairs for reimbursement but requires a certification for all homes that they meet either the IBC, the IFC, or the LSC which are functionally and for a safety standpoint equivalent code requirements.

In addition, the bill does not impose any onerous administrative burden on the Department of Veterans Affairs, only to assure that each facility receiving reimbursement has obtained a certificate of compliance from the local code official or from a competent third party. This requirement mirrors similar requirements for other medical facilities that must provide assurance to the centers for Medicaid and Medicare.

I only had a few moments this morning to review the statements that will be presented by the VA today, but I would respectfully disagree with many of the talking points in that statement.

It is true that veterans' homes covered by this requirement that are located in jurisdictions that does not adopt and enforce either the IFC or the LSC, there will be a small additional burden of obtaining an annual inspection.

However, it is the clear intent of the bill's sponsors and a worthy goal in our opinion that our veterans who sacrificed so much for our freedoms should be provided with safe housing, especially when the taxpayer is subsidizing that housing.

It is hard to argue that our veterans should not be assured of minimal safety in their home when the cost of assuring safety is only a couple of hundred dollars.

In closing, the International Code Council is proud of our work in developing the model codes to assure basic level of safety in the built environment and we applaud your efforts to use those codes to protect the safety of our veterans.

I respect the work of your Subcommittee and encourage continued collaboration between the public and private sectors to achieve the important goal of increased safety in our Nation's buildings.

Thank you very much for the opportunity today and I would be happy to answer any questions.

[THE PREPARED STATEMENT OF ROBERT DREXLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Drexler.

Mr. Kelley.

STATEMENT OF RAYMOND KELLEY

Mr. KELLEY. Mr. Chairman, Members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars, thank you for the opportunity to testify today.

The VFW supports H.R. 1443 which would require the Department of Veterans Affairs to recognize tinnitus as a mandatory condition for research and treatment by the VA auditory center of excellence in coordination with the Department of Defense hearing center of excellence.

Although there is no known cure for tinnitus, it should not be assumed that the condition is untreatable. VA's progressive tinnitus management approach which assists tinnitus sufferers through individual counseling and support is helping veterans better manage their symptoms. Still more research is needed in order to identify truly effective treatments in alleviating these symptoms. This bill represents a positive first step towards achieving that goal.

The VFW supports H.R. 1612, a bill that directs the secretary of VA to convey a parcel of land to Tuskegee University. More than 90 years ago, Tuskegee University donated the land, nearly 300 acres, to the United States Government to build a veterans' hospital. Today 21 of those buildings accounting for nearly 280,000 square foot of space sit vacant on that property.

Annually, VA spends approximately $2.00 a square foot to maintain vacant space. For the buildings that fall within this land transfer, VA spends more than $500,000 a year in maintenance. Reducing the financial burden for upkeep of these buildings and grounds will allow VA to better use those funds to ensure the highest level of maintenance for the facilities to provide care and services to our veterans and not to buildings that are sitting vacant.

The VFW supports H.R. 1702 which permanently authorizes the Veterans Transportation Service or VTS. This program commissioned by the Office of Rural Health in 2010 has greatly improved

access to care for rural and seriously-disabled veterans by allowing VA facilities to establish and coordinate a network of local transportation providers.

In 2012, the program was temporarily suspended following a determination by VA Office of General Counsel that VA lacked the statutory authority to hire paid drivers to transport veterans.

Congress wisely passed a one-year authorization of the VTS program in January of 2013, but a long-term fix is still needed. This legislation would guarantee the continuation of and further expansion of VTS which plays a critical role in minimizing the challenges many veterans face in traveling to their appointments due to physical disabilities or great distances.

The VFW supports H.R. 2065 which would require facilities that house homeless veterans to meet the relevant local building codes in order to receive per diem payments under VA homeless providers grant and per diem program.

Currently the VA is required to check housing certificates before awarding grants for housing services provided to homeless veterans. However, thorough checks of fire and safety requirements as well as structural conditions of buildings are often overlooked.

This bill requires that current recipients of the per diem payment submit a certification of compliance with local codes within two years of the enactment of this act, giving them ample time to make the necessary improvements.

The VFW believes that VA-funded transitional housing must be safe, secure, and sanitary. This bill will ensure that those standards are met, providing homeless veterans with the best chance of successful community reintegration.

The VFW supports the Long-Term Care Veterans Choice Act which would add language to Section 1720 of Title 38 to allow veterans to receive VA care and require a protracted period of nursing care to provide transfer into adult foster home at their request.

To grant VA the authority to reimburse adult foster homes would provide veterans with the additional residency choice, potentially improving the quality of life for those who would prefer this option.

The VFW strongly believes that all non-VA services should be provided in conjunction with proper care coordination. Currently VA handbook 1141.02, the medical foster home procedures, establishes the policies and standards for VA care coordination for veterans who choose to live in medical foster homes.

The VFW feels that these procedures would ensure adequate care coordination for veterans who choose to participate in fully-funded adult foster care programs. However, these procedures are now set to expire in 2014 and the VFW recommends the care coordination policies outlined in that document should be made permanent by adding them to the language of this legislation.

Mr. Chairman, this concludes my testimony. I look forward to any questions from you or the Committee.

[THE PREPARED STATEMENT OF RAYMOND C. KELLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony.

Well, we have the Chairman of the Full Committee. Would you like to discuss your piece of legislation before we get to the questions?

STATEMENT OF CHAIRMAN JEFF MILLER

Mr. MILLER. If I could. I appreciate it. I did not walk in here to automatically start talking about my piece of legislation, but——

Mr. BENISHEK. If it is all right with the Committee, we will let the Chairman go for five minutes.

Mr. MILLER. Thank you very much. I appreciate it, Mr. Chairman.

Thank you to the witnesses.

I apologize for stepping in front of the questioning, but I want to talk to you about the Long-Term Veteran Care Choice Act and I think it is something that this Committee can certainly get behind and support because this act would authorize the Department of Veterans Affairs to enter into a contract or agreement with a certified medical foster home to pay for the residential long-term care of service-connected veterans who are eligible for VA-paid nursing home care.

As a component of such care, eligible veterans would also be required to receive VA home health services.

VA medical foster homes for those of you who do not know are private homes in which a trained caregiver provides 24-hour around-the-clock care to a few individuals. They are designed to provide a non-institutional long-term care alternative to those who prefer a smaller, more like home setting, one that they are more accustomed to in their own homes than traditional nursing homes are able to provide.

VA has been helping to place veterans in medical foster homes now for well over a decade. MFH are limited to no more than three veterans at a time and veterans living in such homes are provided with VA, with home-based primary care services.

They also provide safeguards to ensure that veterans themselves are safe, that they receive high-quality care by requiring the MFH caregivers to pass a Federal background check and VA screening and agree to undergo annual training. And they also allow VA adult foster home coordinators and members of a VA home care team to make both announced and unannounced visits.

Today, according to VA, over 400 approved caregivers provide this type of care in their homes to over 500 veterans daily in over 35 states.

The problem is, however, that VA does not have the authority to pay for the cost of this care. So the veteran who chooses to live in an MFH must pay out-of-pocket with their own personal funds regardless of whether or not such veteran is eligible for VA-paid nursing home care.

What this does is create a situation where many service-connected veterans with limited financial resources who would prefer to live in a medical foster home go to a nursing home institution instead because VA will cover the cost of the nursing home but not the foster home.

And while traditional nursing homes will always be a vital component of long-term care, medical foster homes provide a worthy alternative for many of our veterans.

According to the department itself, many more veterans would elect to receive care in a medical foster home should VA be granted the authority to pay for such care.

And I am sure we all agree that one thing we owe our veterans, particularly those who are service-connected and in need of long-term care, is the luxury of choice, the choice to decide where, whether, and how they receive care.

As the veteran population continues to age, the need for long-term care services will, in fact, continue to grow. The Long-Term Care Veterans Choice Act would expand the long-term care choices that are currently offered to veterans beyond traditional services.

In addition to being beneficial for the health and the well-being of veterans, the average cost of a medical foster home is less than half the monthly cost of a nursing home, making this legislation a very cost-effective health care option.

This is a common-sense veteran-centric bill that will free many veterans from financial turmoil and allow them to make their own decisions about what kind of long-term care they themselves want to receive.

I looked forward to working with all the interested parties to resolve any issues they may have during today's discussion.

And, Mr. Chairman, thank you so much for allowing me the opportunity to talk about this particular piece of legislation at today's hearing.

And I also want to personally thank you for your hard work as Chairman of this Subcommittee. It is very critical work for the veterans of this country and your leadership is greatly appreciated, and I yield back.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Chairman.

I am going to yield myself five minutes for a few questions for the panel.

Dr. Shore, I have a great interest in tinnitus as well because I realize it is a very prominent and probably the most frequent disability that we see from our veterans returning home now.

Several veteran service organizations with the *Independent Budget* raised concerns about protecting and preserving the VA research funding decisions by the scientific merit-based peer review process without interference from outside stakeholders.

Please comment on that concern. Do you feel that this would compromise in any way the current peer review system already in place?

Ms. SHORE. I am not sure what you are referring to by outside——

Mr. BENISHEK. Well, I think the VA contends that they have a peer review process for determining how to fund research and they feel that, outside influences like Congress directing the way that we conduct research would take away from, the peer reviewed med-

ical decision-making process of determining where the funds should go.

Ms. SHORE. Right. No, I do not agree, but I would——Yeah, I see where you are coming from. I do not think that it would interfere with that. I think it would enhance that process as long as you have people that you are deferring to or consulting with who know something about the way tinnitus works.

Mr. BENISHEK. Right.

Ms. SHORE. So——

Mr. BENISHEK. What is the current funding level for tinnitus research?

Ms. SHORE. It is about $10 million everywhere.

Mr. BENISHEK. That is the total——

Ms. SHORE. Yeah.

Mr. BENISHEK. —for this country, $10 million a year for the research in tinnitus or is that just the VA?

Ms. SHORE. Yes, it is—no, no. That is the total. So that is much, much, much lower than it should be. So we have increased the funding from what it used to be five years ago.

NIH is now recognizing tinnitus as a separate disorder that needs to be considered for funding. The DoD is also putting forth opportunities for people to submit grants to study tinnitus. But it still is not nearly enough to bring the research into reality because it takes a long time for our research finding to then be taken into a clinical trial.

And we do not want to take research findings into clinical trials unless they have been proven in the laboratory. So it takes a lot of money for research to end up helping patients.

Mr. BENISHEK. No, I realize that amount seems very small considering the number of veterans that are coming home with the problem.

Ms. SHORE. Oh, it is extraordinarily small, yeah.

Mr. BENISHEK. Especially due to the fact that we do not really have much in the way of treatment or understanding of the disease.

Ms. SHORE. Right.

Mr. BENISHEK. So——

Ms. SHORE. Well, I think it is progressing, but we are not there yet. I mean, there has been a lot of progress in the last decade. And as I said, one of the big jumps was in recognizing tinnitus as a brain disorder and not just a disorder of the ear.

Mr. BENISHEK. Right. Right. I did not realize that myself.

Ms. SHORE. Yeah. So it is often triggered by damage to the ear, but the reason that it is a brain disorder is because the brain reacts to the lack of input from the ear and it starts doing its own thing which is what produces the tinnitus.

Mr. BENISHEK. Right.

Ms. SHORE. And many systems within the brain are acting together and so treatments have to involve things other than just sound therapy which is the most available treatment, but not really very effective and in some people, not even effective at all.

Mr. BENISHEK. Right.

Ms. SHORE. So now there is the development of devices that take into account other etiologies than just the ear. For example, the

somatosensory side of things which is going to be even more prevalent in the veterans' population than it is even in the normal population because they get head and neck injuries as well.

Mr. BENISHEK. Right.

Ms. SHORE. And so the hearing loss combined with the head and neck injuries which themselves can cause tinnitus makes, you know, that the reason——

Mr. BENISHEK. I think you explained that we need a little more research in this department——

Ms. SHORE. Yeah.

Mr. BENISHEK. —pretty well. I want to get to one other topic before my time runs out. I thank you for your answer.

Mr. Gadd or Mr. Kelley, I have an issue with VA transportation in rural areas. I am representative of rural northern Michigan. And the DAV vans are being manned by more and more elderly veterans and we have difficulty in providing adequate transportation for veterans.

I guess my concern about VA—I want to be sure that we use that money very efficiently. Like some of you mentioned, that money is being diverted for transportation away from patient care.

So how do you think that we should do oversight? I am concerned about the fact that we hire a driver, we buy a van, and then they sit there for 80 percent of the time, How do we conduct of oversight that to ensure it is an efficient system within the VA?

Mr. Gadd, do you have an idea or Mr. Kelley?

Mr. GADD. Sure, I can respond to that. And thank you for the question.

So I believe it was mentioned earlier and the VA will have their particular figures on the cost savings, but when these mobility managers came in with the VTS program, they really aligned, they worked together with beneficiary travel. And so there are some reduced cost savings from beneficiary travel. And, you know, in addition to that, they were developing a tool to be able to manage the cost and looking at cost and trying to reduce the cost.

The other point that was mentioned earlier was about special mode transportation. And the VA would have to contract with third-party providers to, you know, provide that transportation. But if they are able to have the ability through the VTS program to do that in-house, there would be some reductions in cost there.

And then, too, it just makes sense because it is one additional option that, you know, if veteran service organization drivers cannot take that, you know, van to that veteran, you know, and they are outside of an area where transportation is not offered, it could reach those particular veterans.

So we see it as a win-win for veterans.

Mr. BENISHEK. Right. Mr. Kelley, you have any input there?

Mr. KELLEY. I will just echo a sentiment. Beneficiary travel is hard to have oversight of. Veterans come in and make a claim that they traveled to their appointment. VA receives the claim and then provides a check in return.

With this, I think it would be easier to do accountability if you have a contractor who says we went to pick up these ten. There is evidence of that, that they brought them to their appointment and then took them home.

So I think in the long run, the oversight would be much easier doing this VTS than beneficiary travel. And I think Mr. Gadd said there is evidence that it will be a cost savings.

Mr. BENISHEK. Thank you, gentlemen.

I have overstepped my time a bit, but, Ms. Brownley, do you have questions?

Ms. BROWNLEY. Yes. Thank you, Mr. Chair.

I wanted to go back, Dr. Shore, and ask you a few more questions about tinnitus.

So I am happy to hear that actually NIH and DoD are getting involved in recognizing this as a serious problem. I am interested to know. You talked a little bit about the research or the lack thereof, but I am interested to know where the promising research is. You talked about, you know, damage to the ear, the brain being two possible causes for this disease.

Is the research going more towards, being more directed to brain research or——

Ms. SHORE. Yeah. I think the strong research that has begun over the past decade or so has been targeting brain mechanisms. And so there are many laboratories now around the country. Some of them do imaging studies with humans. Many of them use animal models because with the animal models, you can go into the brain and record from single cells and see what happens to those single cells after a noise exposure or after a head and neck injury.

And so a lot of our understanding has come from those animal models that show that after, especially after noise exposure which is a lot of where the studies focus on, the neurons in certain specific parts of the brain become hyperactive.

So they are firing along as if there were a sound there and higher neurons up there are interpreting that as a sound whereas, in fact, there is no sound.

And then another thing that is being discovered is that it is not only auditory centers in the brain that are involved in tinnitus but non-auditory centers as well. Some of those I have already mentioned such as the somatosensory system.

So many people who have tinnitus, if they clench their jaw or push on their face, they can make their tinnitus louder or softer or change the frequency or even make it go away. And that highlights this interaction between the touch sensitive neurons and the auditory neurons.

Another area of strong research over the past few years has been the connection between tinnitus and depression. And it is often comorbid and it is often comorbid again in disorders such as PTSD. And it could be that the reason for that is because the brain mechanisms are targeting both of these centers.

So it is, you know, not necessarily, you know, the chicken and the egg stories. It may be that these conditions developed together and you do not just get depressed because you have tinnitus, but that depression and tinnitus sort of exhibit themselves together.

And so some of the research is targeting those areas. I could go on for a long time.

Ms. BROWNLEY. But the damage to the ear then, it seems to me as someone who does not have a medical background or a science background really at all, it seems if there was damage to the ear

that that is something that could be fixed, that perhaps would be a cure. So it seems to me that it is much more on the brain sensory side.

Ms. SHORE. Yeah. So one of the big questions with tinnitus is that even some people who have noise damage and hearing loss do not get tinnitus and why is that? We need to understand that because if we understand that, maybe we could prevent the people who do get tinnitus from getting it.

But even if somebody does not have a hearing loss, they can get tinnitus. And that has been a big area of research recently because audiology clinics, you know, can measure and they can show that people do not have hearing loss. But if you do more sophisticated hearing tests, you can show that hearing actually is affected at a much milder level, enough to trigger a tinnitus in the brain.

Ms. BROWNLEY. Thank you.

And any research, we have talked about the research in the United States, is there any research outside of the United States internationally that is any different than what you have just discussed?

Ms. SHORE. Well, there are some research organizations outside of the U.S. that have actually been very instrumental in pushing tinnitus researchers forward even within the U.S. And some of them are based in Germany and England. And they are trying their best as well separately and together to try to push tinnitus research forward so that we can find a cure.

Ms. BROWNLEY. And is there some coordination that we are doing between investments in the research now that other agencies, NIH and you said DoD is providing some grants and what the VA is doing?

Ms. SHORE. Coordination in what sense?

Ms. BROWNLEY. Well, coordination in terms of, you know, progress or the research that needs to be done before, you know, to pursue a clinical trial.

Ms. SHORE. Right. Well, there are scientific meetings that are very important that, you know, most people who do research in tinnitus will go to those meetings and present their findings and have discussions, set up collaborations.

And that is the major source of information transfer as well as publication of papers. And that is going to be available to everybody, not just within a certain organization.

Ms. BROWNLEY. And of our veteran population that is suffering from this, do you have some percentage of our veterans who we just have not provided any kind of successful treatment for it?

Ms. SHORE. Well, I think the majority is not getting really successful treatment because there is no cure. And like, you know, I mentioned that there is a treatment program that is available that does help, I think, to some extent because even a person who comes in who has tinnitus, if they are told that this is not due to some life-threatening condition, that makes them feel better. But that does not make their tinnitus go away.

Sound therapy is like masking. It sort of masks out the tinnitus for some people some of the time, but it is not actually getting rid of the tinnitus. And so currently there are not any standard treat-

ments that we could say everybody should use this and their tinnitus will go away.

But there are a number of tinnitus treatments that are being developed in research labs that are being tried out in animal models and that are being moved for clinical trials. And some of those are extremely promising because they are targeting the root of the disorder and trying to change brain circuitry.

Ms. BROWNLEY. Thank you.

And thank you for the additional time. I yield back.

Mr. BENISHEK. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

A quick question first for Mr. Drexler. You do mention a few of the rural areas might not have a code that you referred to.

And then how are those situations handled and in your mind, how should they be handled in terms of these inspections? Who would inspect and what would be the basis for those inspections?

Mr. DREXLER. Essentially, the firm would hire a third-party inspection agency and that is becoming very common across the country.

A simple example would be the State of California. We have all gone through, you know, the economic downturn. And California really took a big hit and they were forced to reduce numbers within their building and fire prevention staffs, inspection staffs, and went and began hiring third-party inspection agencies.

Third-party inspection agencies would provide those inspections. They meet the certain qualifications that are established by and within the municipality and would ensure that——

Mr. HUELSKAMP. Mr. Drexler, a quick question. If there is no code specified by the municipality or the county or the state as a mandate, what should be the code, the basis of the inspection then?

Mr. DREXLER. What should be the code if there is no code within that municipality? I think the legislation here would draw the need to require either the I codes or the life safety codes and recommend and require those codes to be in place within the municipalities that do not have building and fire prevention codes.

Mr. HUELSKAMP. So the municipality would be forced to adopt those?

Mr. DREXLER. Yes.

Mr. HUELSKAMP. Under this legislation. Okay. Well, thank you. One other question though. I appreciate that.

Follow-up, a little bit more on the transportation issue. I did a town hall in Syracuse, Kansas one week ago or eight days ago. Same gentleman that was there a year ago brought up the same story again. I am sure you hear that from rural areas.

In this case, he was asked to drive 524 miles to have blood drawn. And it is just crazy. Cannot get the VA to figure out that there are a dozen hospitals along the way including one in his hometown. And here we are talking about encouraging transportation, although we are encouraging to allow him to go a few blocks to the local hospital.

What should I tell this veteran? What do I need to be doing?

I cannot seem to get the VA to figure this out. He has mentioned that to them again, 524 miles to get his blood drawn. And it does not matter whether you have a contract issue of who drives him.

It is himself. And as long as he drives what, three times a month, he can be reimbursed but not if he drives less.

Any thoughts on that from the veteran service organizations? What are we supposed to be doing here? This is just unacceptable and I cannot get an answer for him that works.

Mr. Gadd.

Mr. GADD. I can answer that question. We testified, The American Legion did in the fall last year about fee-basis and non-VA care coordination. And, you know, we said that the VA should exercise discretion based on patient-centered approach.

And that approach is that, you know, we can understand if they go for a major procedure within a VISN or near an area, but to have multiple trips a couple days a week, you know, for dialysis, you know, look at other options closer to that veteran's community.

And I think that that is a perfect way to—in this case, what was the local options? What was the closest community-based outpatient clinic? Is there a demand for laboratory services there in that area? Maybe that is something that the gentleman from the VA could address this morning.

But we would argue that if it is multiple trips, and it is inconvenient, that the VA does have that authority to allow that veteran to be treated there locally near his home.

Mr. HUELSKAMP. Do you think that in your mind they do not want to allow that or it gets lost in the shuffle or they just generally do not want to allow that? What is your thought on the VA's——

Mr. GADD. They implemented the non-VA care coordination is the new rollout of that program. And they are trying to standardize procedures and how they formulate those decision-making abilities.

You know, but we have argued that the veteran should have a say in that process and that there should be some recourse that the veteran has to appeal that decision, you know, and not have to drive 500 miles to get a blood draw. You know, that is ridiculous.

Mr. HUELSKAMP. Mr. Kelley or Mr. Atizado, any thoughts?

Mr. ATIZADO. I am just going to echo what Mr. Gadd mentioned. That local VA facility, the parent facility that that veteran is driving to, has the authority to pay for that service or that lab service at the closest location to the veteran's residence.

There are various reasons why a facility would choose not to exercise that authority. And I do not think we can discuss that at this point without all the information in front of us.

But, nonetheless, that veteran should be able to speak to their primary care physician or social worker and hopefully that health care team will say, you know, 500 miles is a little too much.

But, again, I cannot answer one way or the other why that is, just to say that VA does have the authority.

Mr. HUELSKAMP. Is this a situation you hear about with regularity? How often does it happen? Is it just one guy in Syracuse, Kansas or is it something that you continue to hear from your constituents about as well?

Mr. ATIZADO. Well, as far as getting care in the community, we hear it more often simply because it is an issue that is brought up as opposed to a veteran who does get care in the community and

does not say, hey, I got care in the community, it is great. They have nothing to contact and complain to us about.

So, yeah. So there are issues like that where a veteran is not being allowed by VA to go to a local or community service and have VA pay, which is not to say that the issue of transportation is without issues as well, but this is an issue.

That is why VA, as Jacob mentioned, has a non-VA care coordination office set up to establish some semblance of compassion in the fee-care program to make it more patient centered.

Mr. HUELSKAMP. Okay. Thank you, Mr. Chairman, unless Mr. Kelley had some thoughts. Thank you. I yield back.

Mr. BENISHEK. Well, I would like to thank the Members of the panel for their testimony today. It was very enlightening and I do appreciate your comments and look forward to any further input you want to give to me in the future on this bill.

So thank you very much for your participation and you are excused.

We will now call Dr. Jesse as he is the sole member of the third panel.

You can begin when you are ready, Dr. Jesse.

STATEMENT OF ROBERT L. JESSE, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY SUSAN BLAUERT, DEPUTY ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Good morning, Mr. Chairman and Ranking Member Brownley and Members of the Subcommittee.

We do appreciate your continuing efforts to support and improve veterans' health care and we thank you for the opportunity to address the bills on today's agenda along with their impact on VHA's health care operations.

Joining me today is Deputy Assistant General Counsel Susan Blauert.

And I would also like to thank Chairman Miller for coming by earlier.

VA recognizes the importance of each one of these bills and we are committed to work with you and the Members of the Subcommittee and Congress on legislation that can enhance our ability to provide health care to our Nation's veterans.

I am going to address a few key points on each of the bills today, but the more detailed explanations are available in my written statement.

Regarding the draft, Long-Term Care Veterans Choice Act, VA supports the concept of medical foster homes as an alternative to long-term institutional care as requested in VHA's fiscal year 2014 budget submission.

We appreciate your interest in the concept, but we do need additional time to continue technical assistance to the Committee and particularly on details pertaining to the term adult foster home versus medical foster home, the payment methods, and cost analysis.

VA strongly supports H.R. 1702 which would make permanent the authority to hire qualified drivers to expand access to VA

health care for individuals traveling to and from VA health care appointments.

In 2012, though, Veterans Transportation Service or VTS provided more than 199,000 one-way trips totaling more than 9.7 million miles. The average length of a one-way trip is over 48 miles and it is a considerable distance and often would be prohibitive for those with poor health were transportation not available.

Veteran service organizations are invaluable in providing volunteers to drive veterans to their appointments. However, there are often not enough volunteers to meet the level of need. More importantly, they are often precluded from transporting veterans with various clinical issues such as portable oxygen, as you heard. We do not see VTS as competitive, but rather supplemental to the important role played by the VSOs.

VA is in agreement with the goal of H.R. 1443, the Tinnitus Research and Treatment Act of 2013, which would recognize tinnitus as a mandatory condition for research and treatment and require cooperation with DoD to perform further research.

However, the bill describes programs and operations that already exist within VA. Our audiology clinics already provide tinnitus treatment through a progressive tinnitus management program which includes group educational counseling treatment and individualized management.

VA has active projects underway in researching the efficacy of this multidisciplinary tinnitus treatment, the underlying etiology of tinnitus, and the co-occurrence of hearing loss along with tinnitus.

VA is also collaborating with DoD on the development of a registry of the critical information to track the diagnosis, surgical interventions, or medical treatments for tinnitus and to follow-up for each case of hearing loss and auditory system injury incurred by servicemembers while on active duty.

Currently, VA has the responsibility to ensure the safety of veterans cared for in its grant and per diem or GPD facilities through on-site inspections of each facility by staff from the local VA medical center. Inspections are focused on compliance with the requirements of the life safety code of the National Fire Protection Association.

The inspection team is responsible for ensuring that general operating requirements as noted in GPD regulations are met.

VA believes these measures ensure the safety of those properties and recognizing that as the intent of H.R. 2065, we do have some concerns with the bill as written. Specifically, we are concerned that H.R. 2065 will shift the cost of certifying compliance with life safety code or other applicable codes to the GPD grantees.

Currently, VA covers the cost by inspecting the GPD facilities for compliance with life safety code at no charge to the grantee. Over 96 percent of current GPD projects are operated by non-profit community-based providers. Any increased operating costs for these grantees could have a negative impact on the type and quality of services provided to veterans.

We are also concerned that H.R. 2065 could have an inequitable impact on GPD providers in rural areas because of the difficulties of assessing qualified inspectors to certify compliance in those areas.

We do not yet have testimony on H.R. 1612 which would authorize VA to transfer a 64.5 acre tract to Tuskegee University or as noted previously from the draft, Long-Term Care Veterans Choice Act.

However, we look forward to working with the Committee in providing technical assistance on these and any other bills before the Committee today.

This concludes my remarks. On behalf of the department, thank you again for the opportunity to provide our views and be pleased to answer questions.

[THE PREPARED STATEMENT OF ROBERT L. JESSE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. Jesse. It is a pleasure to see you once again before the——

Dr. JESSE. Thank you, sir.

Mr. BENISHEK. —Committee. I have a couple of questions. I will yield myself five minutes.

Is there a difference in what you are saying about the amount of research in tinnitus?

You said you are already doing research because I think this $10 million number is what keeps sticking in my mind, that there are so many episodes of tinnitus and you have $10 million for a multi-billion dollar problem. It does not seem like much. So you seem to say something that you are already doing something about it.

Is that $10 million number wrong then?

Dr. JESSE. Well, that $10 million number, I think, was nationally, not just VA, nationally. VA's investment is about $1.2 million, so about a tenth of that is in VA, mostly in four projects, three of which are really focused on the clinical assessments, one specifically which was called for in the bill to look at the efficacy of this multi-step treatment program.

Mr. BENISHEK. You do not dispute that number then? That number seems reasonable to you?

Dr. JESSE. Oh, no. Actually, I think that is a pretty small number compared to what we spend on a lot of other things.

And I think what is interesting is, as Dr. Shore noted, that there has really been, I think, a dramatic change in the past, I will just say a couple of years, through new imaging modalities that are really beginning to describe the functional changes within the brain in patients with tinnitus historically which has really focused on it being an ear problem.

But those technologies are relatively new and it takes time to get that kind of work into the, you know, the life cycle of research.

But, yeah, I think it is—I guess I do not know that I can say it is underfunded because there is not enough money for the research or it is underfunded because there has not been the kind of high-quality grants proposals coming through the system in order to get them funded.

Mr. BENISHEK. So it is not like you are in favor of the legislation.

Dr. JESSE. Well, we have no problems with the legislation. I think basically what is described in the legislation is stuff that we are already doing.

I guess the one issue, and just to be very clear because of the dynamics of research, is remember that VA is only authorized to do intramural research. We cannot fund extramural research. That is one of the reasons why we value the research partnerships with DoD who can.

Mr. BENISHEK. Okay.

Dr. JESSE. And I do not have the numbers for DoD.

Mr. BENISHEK. Well, that is an interesting point there.

I have another question for you, too, and that is this transportation issue.

Dr. JESSE. Uh-huh.

Mr. BENISHEK. And that is something I think we may have talked about before, and that is the fact that it came out here in the earlier panel with Mr. Huelskamp pointing out the fact that—are we going to transport more patients, make it easier to transport the patient 500 miles or are we going to use, the local community access mode and how are we going to balance that.

I have been to town hall meetings myself where veterans have said to me, I cannot get to the place I want to go to get my x-ray and the other guy said, well, I can get the x-ray right here. So one veteran wants to go the 100 miles to get the chest x-ray. The next veteran does not want to go the 100 miles to get the x-ray.

So I know there is a lot of individual variability in the patient preference. And I do not really know the best answer to that myself. I think now it all happens at the VA.

My concern is the fact that, does the patient have an opportunity to call back once he gets an order to come in for an x-ray or a blood test, he can just call the VA back and say can I get the test done at my local hospital without having to go back to the initial doctor because sometimes that can be the problem?

And the person who is answering the phone cannot get a hold of the regular doctor, or does not have the authority to make that decision.

I think in the practical terms of how that gets done, there may be some problem, when the patient says I would rather get it done in my hometown and then the person they talk to on the phone does not have the authority to do that and cannot get a hold of the person that does.

How does that actually occur and how do we make it better for the patient?

Dr. JESSE. So I think this is one of the reasons why we are, as Jacob Gadd mentioned, the notion of having the coordinator for non-VA care, so there actually is a person who could make these kinds of decisions without somebody getting into the swirl of administrative phone tag.

I know my patients, some that live still in Richmond where I still have my clinic, we draw from northern, you know, down into Roanoke Rapids areas of North Carolina and the far south West Virginia, some people have to travel fair distances. I mean, I think that common-sense is the thing that will prevail here.

And I have patients who, for instance, are on Warfarin who have to have their INRs checked. Most of them will get it checked locally and they will also get it managed locally. Occasionally people will

get it done at the VA because they are coming up for a lot of other things and we can coordinate the visits around that.

I think traveling 500 miles to get a blood drawn is kind of beyond common sense. I mean, if you are looking at a cost-basis, what we pay for benny travel, far exceeds the cost of that test.

And the other piece that comes in here and one of our real fears many times is that the lack of coherence of the information, meaning if it is done in the VA, we can track it through our electronic medical record. It is there for everybody to see. There really is the continuity of care-based on the information. When it is done outside and gets reported, it often gets lost.

And, you know, obviously a lot of what is going on nationally around health IT is meant to take some of those things into place. But I think we really try to do what is best for the patient and, you know, I am sorry to hear that some people have problems like this. I think that we need to be doing better in those cases.

Mr. BENISHEK. Do you think that this coordinator, this person is going to make the difference then? That is what you are telling me.

Dr. JESSE. Well, I think the primary care, you know, as we move to team-based care, as we move to the idea that you now have actually a direct connection in and you should not be having these, I cannot get my provider type of things, and those decisions can get made and taken care of that way.

Mr. BENISHEK. My time is up here. I will leave it to Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chair.

I just also wanted to follow-up again on this tinnitus and the role of the VA in it. I mean, it seems to me that, you know, $1.2 million is not enough for the VA's participation.

And it seems to me if this is something, and clearly it is, that our veterans are suffering from, that the VA should be taking a significant leadership role in trying to lead the research to find cures for this.

It is clearly costing the VA a lot of money for treatment that does not seem to necessarily have great outcomes. And I think always with research, if there is a will, there is a way. And it seems to me that the VA should be the leader in this area.

Dr. JESSE. So I think from a clinical perspective in the treatment of tinnitus, we are. In terms of the basic research, I do not know that we are not because obviously there is not a lot going on in the country as it is.

But as I mentioned, I think one of the issues is it has been a problem because we cannot quantitate it. We do not have a biomarker for it. And so we do not have a cure for it because we do not really understand in many cases what causes it. And so we have had to focus on the treatment and amelioration of the symptoms.

Now with newer imaging modalities and better science, I think we are going to get a much better handle on the basis of the disease. And then when one can understand that, you can begin to define treatments that get to the root source rather than treating the symptom.

Ms. BROWNLEY. Well, I mean, in Dr. Shore's testimony anyway, it seemed as though the treatments generally are not as successful,

I guess, as we would like them to be. And if that is our leadership, it does not seem to me to be adequate because we are not necessarily treating the condition successfully and, yet, we also do not have a cure.

So it just feels to me very much like we should be in a better leadership role around this because it is our customers, it is our constituents who are suffering from it and we should not be dependent on sort of outside research in hopes of, in hopes of coming up with a cure.

I also just wanted to ask why at this moment you do not have a position on H.R. 1612? Is that what I heard you say, that you did not have a position?

Dr. JESSE. Oh, it is for Tuskegee.

Ms. BROWNLEY. Yes.

Dr. JESSE. So just to be clear, we have no issue with transferring the land. It is a technical issue about what is required before we can do that. And so my understanding without stepping over my knowledge-base or bounds on this is that in order for us to transfer land back, certain assurances have to be made. And those are already existent in other Federal statutes. And so those have to be completely vetted and understood and then we will work through the process.

Our objection is not in the transferring of the property. It is making it happen in a way that meets all the requirements and we just have not fully understood all of them yet. And also what that is going to mean is, there is going to be some cost associated with it that will have to be borne by somebody. We just do not know what that is yet and that is why we do not have the views.

Ms. BROWNLEY. Thank you. I yield back.

Mr. BENISHEK. Thank you, Ms. Brownley.

Well, I think I have so many questions I could go on for a couple more hours. To tell you the truth, there was a lot of interesting things that came up in all the panels today. I may put some written questions——

Dr. JESSE. Sure.

Mr. BENISHEK. —for the record to even some of the previous panels because these are such an interesting subjects and I think deserve a little more thought.

So I want to thank you for your testimony today, Dr. Jesse, and thanks to all the other people that testified today. You are excused, Dr. Jesse.

I ask unanimous consent that all the Members have five legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

I would like once again to thank all the witnesses and the audience members for joining us in today's conversation.

The hearing is now adjourned.

[Whereupon, at 11:46 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Dan Benishek, Chairman

Good morning. The Subcommittee will come to order.

Thank you all for joining us this morning to discuss five pieces of legislation concerning the health care and services available to our honored veterans through the Department of Veterans Affairs' (VA's) health care system.

The five bills we will discuss today are:

- Draft legislation, the Long-Term Care Veterans Choice Act;

- H.R. 1443, the Tinnitus Research and Treatment Act of 2013;

- H.R. 1612, to direct the Secretary of Veterans Affairs to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University;

- H.R. 1702, the Veterans Transportation Service Act; and,

- H.R. 2065, the Safe Housing for Homeless Veterans Act.

From ensuring the safety of homeless veterans residing in VA Homeless Grant and Per Diem facilities to ensuring that veterans eligible for VA-paid nursing home care are able to receive care in certified medical foster homes should they choose, these five bills address a number of critical issues facing today's veterans and all of us charged with caring for them.

I am eager to discuss each of these proposals in-depth to ensure a thorough understanding of their purpose, intended benefits, and unintended consequences.

I am grateful to my colleagues who sponsored these bills and to our witnesses for being here to discuss them with us.

I look forward our conversation.

With that, I now yield to Ranking Member Brownley for any opening statement she may have.

Prepared Statement of Hon. Julia Brownley

Thank you, Mr. Chairman.

The purpose of today's hearing will be to explore the policy implications of five bills before us today which cover a wide range of topics that would expand and enhance VA's health care programs and services. To allow maximum time for discussion, I will limit my opening remarks primarily to H.R. 1443 and H.R. 1702.

H.R. 1443, Tinnitus Research and Treatment Act of 2013, is offered by Ranking Member Michaud.

According to the VA, tinnitus is the number one service-connected disability for veterans from all periods of service, affecting over 840,000 veterans. Since 2005, the number of veterans receiving service-connected disability for tinnitus has increased by at least 15 percent each year, and VA has been paying out over $1.2 billion annually to veterans for tinnitus disability compensation. At the current rate of increase, service-connected disability payments to veterans for tinnitus will cost $2.26 billion annually by 2014. Nevertheless, only about $10 million is dedicated to researching tinnitus in the public and private sectors.

H.R. 1443 will allow for appropriate research time and resources by directing VA to recognize tinnitus as a mandatory condition for research and treatment by the VA Auditory Centers of Excellence. This will make certain that research is conducted at VA facilities on the prevention and treatment of this condition, and that VA cooperates with the Department of Defense's Hearing Center of Excellence to further research on tinnitus. H.R. 1443 would ensure that we remain on the cutting edge for research and treatment of this issue facing veterans of all ages.

Next, H.R. 1702, introduced by Mr. Barber of Arizona, would permanently authorize VA to operate the Veterans Transportation Service (or VTS), which provides transportation for individuals to and from VA medical facilities in connection with vocational rehabilitation, counseling, examination, treatment, or care. VTS was launched in 2010, and VA's current authority to operate the program is set to expire in January of next year.

I did want to emphasize the critical need for this legislation in helping to increase access to care for those who would otherwise face challenges in getting to and from their appointments at VA. I also wanted to highlight that VA has estimated VTS to save up to $19.2 million in FY14 and $102.7 million over five years, because it is less expensive for the VA to hire drivers through VTS than to contract with ambulance services or to provide mileage reimbursements. So this is simply a commonsense initiative.

Thank you, Mr. Chairman, for including these bills on the agenda. I look forward to hearing the views of our witnesses on the legislation before us today.

Thank you, and I yield back.

Prepared Statement of Hon. Jeff Miller

Thank you, Dan.

It is a pleasure to be here again with you, the Subcommittee on Health, and all of our witnesses, stakeholders, and audience members to discuss my draft bill, the Long-Term Care Veterans Choice Act.

The Long-Term Care Veterans Choice Act would authorize the Department of Veterans Affairs (VA) to enter into a contract or agreement with a certified Medical Foster Home (MFH) to pay for the residential long-term care of service-connected veterans who are eligible for VA-paid nursing home care. As a component of such care, eligible veterans would also be required to receive VA home health services.

Medical foster homes (M–F-Hs) are private homes in which a trained caregiver provides twenty four hour, around-the-clock, care to a few individuals. They are designed to provide a non-institutional long-term care alternative to those who prefer a smaller, more home-like and familial care setting than many traditional nursing homes are able to provide.

VA has been helping to place veterans in medical foster homes for over a decade. VA, as part of the placement process, inspects and approves all MFH's, limits care to no more than three veterans at a time, and provides veterans living in such homes with home based primary care services. VA also provides safeguards to ensure veterans receive safe, high-quality care by requiring MFH caregivers to pass a Federal background check and VA screening, agree to undergo annual training, and allow VA adult foster home coordinators and members of a VA home care team to make both announced and unannounced home visits.

Today, according to VA, over four hundred approved caregivers provide MFH care in their homes to over five hundred veterans daily in over thirty five states.

The problem, however, is that VA does not have the authority to pay for the cost of the MFH. So, the veteran who chooses to live in a MFH must pay out of pocket with personal funds – regardless of whether or not such veteran is eligible for VA-paid nursing home care.

This creates a situation where many service-connected veterans with limited financial resources, who would prefer to live in a medical foster home, go to a nursing home institution instead because VA will cover the cost of the nursing home, but not the MFH.

And, while traditional nursing homes will always be a vital component of long-term care, medical foster homes provide a worthy alternative for many veterans.

According to the Department, many more veterans would elect to receive care in a medical foster home should VA be granted the authority to pay for such care.

I am sure we all agree that one thing we owe our veterans, particularly those who are service-connected and in need of long-term care, is the luxury of choice - the choice to decide where and how to receive the care they need.

As the veteran population continues to age, the need for long-term care services will continue to grow. The Long-Term Care Veterans Choice Act would expand the long term care choices offered to veterans beyond traditional services. Additionally, in addition to being beneficial for the health and well-being of veterans, the average cost of a MFH is more than half the monthly cost of a nursing home, making this legislation a very cost effective health care option.

This is a common-sense, veteran-centric bill that will free many veterans from financial turmoil, and allow them to make their own decisions about what kind of long-term care they want to receive.

I look forward to working closely with all interested parties to resolve any issues that may arise during today's discussion.

Thank you once again, Dan, for holding this hearing today and for the hard work and leadership shown by you and all of the Members of this Subcommittee. And, with that, I yield back the remainder of my time.

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman and Ranking Member, it's an honor to serve on this Committee.

I thank you for holding this legislative hearing to enable relevant stakeholders the opportunity to improve legislation directly impacting them.

I also want to thank the veteran service organizations testifying today and those in attendance. The selfless work your organizations perform continues to inspire Members, such as me, to remain steadfast in our commitment to improving veteran health care.

The Veteran Health Administration oversees an extensive integrated health care system. In fiscal year 2012, approximately 8.76 million veterans were enrolled in the VA health care system—with approximately 6.33 million unique patients treated. [1] While these are impressive numbers, we must not get buried in statistics and lose sight of what is most important—the veterans who have earned their right to quality and accessible health care.

I look forward to working with my colleagues and our panelists on this legislation before us.

Thank you.

Prepared Statement of U.S. Rep. Mike D. Rogers

H.R. 1612

Thank you Chairman Benishek and Ranking Member Brownley.

First, I would like to thank you Mr. Chairman and your staff for holding this hearing today. I also want to thank the Full Committee Chairman, Jeff Miller, for his leadership on behalf of our Nation's veterans.

Mr. Chairman, H.R. 1612 will benefit the Department of Veterans Affairs (VA), the people of Tuskegee, Alabama and the taxpayer.

In 1922, the board of Tuskegee University voted to donate 300 acres of land to the federal government for a veterans' hospital. Since that time, the Tuskegee VA hospital and Tuskegee University have grown into integral parts of the community and serve important roles for our nation. Now, as the VA refocuses its mission to better serve our veterans, some of the donated land near the University's campus no longer fits the VA's needs.

My bill would transfer 64.5 acres of land at 2400 Hospital Road back to Tuskegee University so that the land can better serve the community. This transfer also creates new opportunities for the VA by reducing substantial overhead and maintenance costs and providing cooperative authority to leverage the strengths of both institutions.

This bill has been scored at no cost to the federal government and is a prudent use of our federal resources. Thank you again for the opportunity to testify Mr. Chairman and appreciate your leadership and strong support for this legislation.

Prepared Statement of Honorable David B. McKinley, P.E.

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee, thank you for holding this legislative hearing today on important issues that affect our nation's veterans. I appreciate the opportunity to give remarks on my bill, H.R. 2065, the Safe Housing for Homeless Veterans Act. This is the same

[1] U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, "Department of Veterans Affairs Statistics at a Glance Pocket Card." Updated 17 April 2013. *http://www.va.gov/vetdata/docs/Quickfacts/Spring—13—sharepoint.pdf.*

bill, with some modifications, that I testified for before the Subcommittee in the last Congress and that passed the House.

Currently, there are over 2,100 community-based homeless veteran service providers across the country and many other homeless assistance programs that have demonstrated impressive success reaching homeless veterans. I have visited some of the shelters in my home district in West Virginia and was struck by how many seemed to not be in compliance with state, local or federal safety codes.

Consequently, we began to investigate how widespread this problem was. It was unsettling to learn about shelter fires where lives have been lost. We read stories of a homeless shelter fire where occupants were killed because there was no sprinkler system at the facility and another where homeless veterans were injured because a sprinkler system was not working properly and the fire exits were blocked. These types of tragedies could have been avoided.

This common sense legislation would ensure the wellbeing of veterans who have fallen on hard times and are in the most need of assistance. There is no current law mandating VA homeless shelters meet code. There is only a loosely defined policy that is not universally being followed. As a licensed professional engineer, I found this to be an egregious omission in the law governing VA homeless program funds.

H.R. 2065 would require any organization that seeks funding from VA for services to homeless veterans to have documentation that their building meets or exceeds all building Codes. Since last Congress we made some modifications to the bill after meeting with stake-holder groups including the International Code Council. The current draft actually makes it easier for facilities to be certified as we open up the requirements beyond only Life Safety Codes to International Building and Fire Codes or any version of these codes that a local jurisdiction has adopted. Furthermore, the legislation would require adding a section in the VA annual report to Congress that would report the number of grant recipients or eligible entities who have submitted a certification that their facility met all building Codes.

I understand that there is some concern over an undue burden for facilities to be certified that they meet or exceed the building codes. We welcome a continued dialogue on possible amendments to the legislation to make sure that this bill is simply requiring the facilities to follow what is already state and local law in most jurisdictions. I am pleased to let you know that we have already begun these discussions with the concerned parties and we are well on our way to a solution.

After passing the House last year, this language was dropped from the final package that became law at the end of the year. As a nation, it should be unacceptable for us to allow homeless veterans be housed in potentially unsafe conditions. In defense of our country, these men and women were put in harm's way; they should not be in doubt about their own safety now that they are home again. These homeless veterans are experiencing a difficult phase of their lives and should be able to trust that they will be safe each night as they continue their return to being productive members of society.

I appreciate the testimony in support of H.R. 2065 from other witnesses testifying here today and I thank you for your concern for the safety and living environment of our veterans.

Prepared Statement of Jacob Gadd

Chairman Benishek, Ranking Member Brownley and distinguished Members of the Subcommittee, on behalf of Commander Koutz and the 2.4 million members of The American Legion, I thank you and your colleagues for the work you do in support of our service members and veterans as well as their families. The hard work of this Subcommittee in addressing the health care needs of the veterans' community makes a substantial impact on the ability for veterans to receive, as they deserve, the best care anywhere.

H.R. 1443: *Tinnitus Research and Treatment Act of 2013*

To direct the Secretary of Veterans Affairs to recognize tinnitus as a mandatory condition for research and treatment by the Department of Veterans Affairs, and for other purposes.

It is no secret that the men and women who serve in the armed forces are potentially subjected to some of the most devastating noise trauma in the occupational world. From noisy jet engines to gunfire and artillery, to say nothing of the potentially damaging shock waves from Improvised Explosive Devices (IEDs), the ubiquitous threat of the recent and ongoing wars in Iraq and Afghanistan, veterans

again and again place their ears and hearing at risk in service to this country. Tinnitus, which can stem from multiple causes, is often characterized as a persistent ringing in the ears, ranging from the distracting to severely disruptive to the ability to concentrate and focus on tasks.

The American Legion provides accreditation for over 2,600 service officers nationwide who work with veterans to assist with claims for disability benefits. As such, this dedicated network is intimately familiar with the types of disorders affecting the nation's veterans. Tinnitus represents the most prevalent service connected disability, with over 840,000 veterans receiving compensation for the disorder as of 2011[1]. With so many veterans affected, research into the disorder is critical.

This bill would ensure a full spectrum of research would be conducted through the Department of Veterans Affairs (VA) into such varied topics as multidisciplinary treatment modalities, underlying etiological studies of the disorder, contrasting types of tinnitus with and without accompanying hearing loss, and other factors. The bill also prompts close cooperation between VA and the Department of Defense, perhaps a key component in preventing future incidences of the disorder. The American Legion "encourages acceleration in the development and initiation of needed research on conditions that significantly affect veterans.[2]" All hearing trauma, be it tinnitus or hearing loss, is a scourge veterans are quite familiar with. Increased research into mitigating the effects of such traumas is a boon not solely to today's veterans, but to generations to come.

The American Legion supports the passage of H.R. 1443.

H.R. 1612:

To direct the Secretary of Veterans Affairs to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University, and for other purposes.

This bill addresses land conveyance between the VA and Tuskegee University.

The American Legion has no position on H.R. 1612.

H.R. 1702: *Veterans Transportation Service Act*

To amend title 38, United States Code, to make permanent the authority of the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with rehabilitation, counseling, examination, treatment, and care.

This bill provides a technical amendment to the existing law in 38 United States Code §111A, eliminating the provision in the current law which causes the authority of VA to expire and making the authority permanent. The authority in question allows VA to provide transportation services, increasing access to their facilities and health services.

The American Legion believes there is a vital need for the Veterans Transportation System[3] to ensure all veterans receive access to the care they have earned through their service and sacrifice. Through the conduct of our many System Worth Saving (SWS) visits to VA health care facilities nationwide each year, our field staff and task force members have seen firsthand the importance of this program in getting veterans to the facilities. Whether through volunteer efforts or the VTS program, many veterans need help to reach treatment and disruption in the ability to provide that help results in a loss of care. Making this authority permanent would help provide stability for planning purposes. The American Legion would further urge Congress to continue to monitor this program and to consider raises as appropriate for beneficiary travel rates[4] as that is also a key component of getting veterans to the hospitals for treatment.

The American Legion supports the passage of H.R. 1702.

H.R. 2065: *Safe Housing for Homeless Veterans Act*

To amend title 38, United States Code, to require recipients of per diem payments from the Secretary of Veterans Affairs for the provision of services for homeless veterans to comply with codes relevant to operations and level of care provided, and for other purposes.

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[1] US Department of Veterans Affairs Annual Benefits Report, FY 2011.

[2] Resolution 108: *Request Congress Provide the Department of Veterans Affairs Adequate Funding for Research and Prosthetic Research,* - AUG 2012.

[3] Resolution 293: *Veterans Transportation System (VTS) & Benefits Travel* – AUG 2012.

[4] *Ibid*.

This legislation requires veterans' homeless shelters to meet all appropriate building and fire codes. Veterans' homelessness is a critical problem. That veterans should have to contend with homelessness is a national shame. Secretary Eric Shinseki has been steadfast in his efforts to bring to bear the resources of VA to combat this issue, and great strides have been made in the last several years in reducing the numbers of homeless veterans on the streets every night.

The American Legion supports the efforts of public and private sector agencies and organizations that aid homeless veterans and their families[5]. Additionally, the Legion supports legislative proposals to provide medical, rehabilitative, and employment assistance to homeless veterans and their families. The American Legion places special priority on the issue of veteran homelessness. To help our struggling brothers and sisters-in-arms, the Legion works on a global level, lobbying for legislation affecting veteran homelessness, and acts on a local level, directly assisting veterans who have fallen on tough times and are without a place to live or facing the prospect of it.

This direct assistance is coordinated by the Legion's Homeless Veterans Task Force, which works to ensure local services and resources are available to homeless veterans and their families. The Task Force, which has chairpersons in each department, collaborates with government agencies, homeless service providers and veterans service organizations to develop and implement initiatives that will help homeless veterans.

The Legion recognizes that aiding homeless veterans requires a sustained coordinated effort, which should provide secure housing and nutritious meals; essential physical health care, substance abuse aftercare and mental-health counseling, as well as personal development and empowerment. Homeless veterans also need job assessment, training, and placement assistance. The ultimate goal is total self management for the homeless veteran.

Homeless veterans cannot be considered to have "secure housing" if they must contend with facilities that don't even meet basic building codes and place these uniquely vulnerable veterans at risk of serious injury or death from fires and substandard building materials. If these veterans have lost their homes and livelihoods, we cannot in good conscience place them at risk to life and limb in unsafe facilities.

This legislation would ensure the facilities designated to serve the needs of homeless veterans comply with appropriate codes and regulations, and give them a stable and safe environment to help piece their lives together as they move forward.

The American Legion supports the passage of H.R. 2065.

DRAFT LEGISLATION: *Long Term Care Veterans Choice Act*

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to enter into contracts for the transfer of veterans to non-Department adult foster homes for certain veterans who are unable to live independently.

Adult Foster Care homes provide an alternative in some situations to traditional nursing home elder care. In general, these are single family homes which provide room, board and supervision as well as personal care services. These types of facilities provide for the needs of the elderly who, though they may require periodic or regular assistance with the activities of daily living, do not require full time nursing services.

Individual states have a variety of rules and regulations related to the governance and approval of such facilities. This draft legislation would modify the United States Code to allow for veterans "for whom the Secretary is required to provide nursing care under section 1710A of [Title 38], the Secretary may transfer the veteran to an adult foster home that meets Department standards, at the expense of the United States, pursuant to a contract or agreement entered into between the Secretary and the adult foster home for such purpose." In essence, this legislation would allow VA to place veterans in these adult foster homes and pay for the services provided. Veterans can currently utilize such homes if they so choose, but they must pay out of their own pocket for the services, even if VA is authorized to pay for nursing care for the veteran.

VA is authorized[6] to provide a comprehensive array of medically necessary in-home services to enrolled veterans. This bill seeks to add a provision in title 38, United States Code (U.S.C.), Section 1720 that VA would be authorized to transfer veterans needing long-term care services to "Foster Homes," upon the request of the veteran or Secretary of Veterans Affairs.

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[5] Resolution 306: *Funding for Homeless Veterans* – AUG 2012

[6] Title 38, Code of Federal Regulations (CFR) Section 17.38 (a)(1)(ix)).

VA issued VHA Handbook 1141.02, Medical Foster Home Procedures, in November 2009, which outlined the Department's policy on definition, responsibilities, selection, training, quality monitoring and financial arrangements for this program.

VA defines a Medical Foster Home (MFH) in VHA Handbook 1141.02 as:

1) MFH is an adult foster home combined with a VA interdisciplinary home care team, such as VA Home Based Primary Care (HBPC) or Spinal Cord Injury – Home Care (SCI–HC), to provide non-institutional long-term care for veterans who are unable to live independently and prefer a family setting.

2) MFH is a form of Community Residential Care (CRC) for the more medically complex and disabled veterans, and is generally distinguished from other CRC homes by the following:

(a) the home is owned or rented by the MFH caregiver;

(b) the MFH caregiver lives in the MFH and provides personal care and supervision,

(c) There are not more than three residents receiving care in the MFH, including both veterans and non-veterans,

(d) veteran MFH residents are enrolled in a VA HBPC or SCI–HC Program.

Each VA Medical Center facility appoints a MFH Coordinator which oversees the recruitment of staff, new applications for MFH in the community, training, quality assurance and inspections, and maintaining files of patients and MFH caregivers.

While this program has been highlighted and encouraged because of the additional cost savings and access to care options for the veteran and VA, The American Legion seeks additional feedback from users of this MFH program about the level of patient safety and feedback on their quality of care that would be provided in a non-traditional care setting. We are continuing to study and monitor this situation to determine the best solution for veterans.

The American Legion has no position on this legislation.

For further questions or comments about this or other legislation affecting America's veterans please contact The American Legion through Ian de Planque, Deputy Legislative Director at *ideplanque@legion.org*

Prepared Statement of Susan Shore

Good morning Chairman Benishek, Ranking Member Brownley, and distinguished members of the Health Subcommittee. My name is Dr. Susan Shore, and I am the Chair of the Scientific Advisory Committee of the American Tinnitus Association. Thank you for holding this important hearing on an issue of concern to our nation's armed forces and those members returning from combat – Tin-night-us or tinn-it-us, most commonly referred to as "ringing in the ears." Tinnitus has long been called the "invisible injury," so because of this, and many other reasons which I will be addressing, it is extremely relevant and timely that tinnitus is recognized as a mandatory condition for research and treatment by the Department of Veterans Affairs. On behalf of the American Tinnitus Association and the 50 million Americans afflicted with tinnitus I appreciate the opportunity to speak to you today and respectfully urge your support for H.R. 1443, the Tinnitus Research and Treatment Act of 2013.

The American Tinnitus Association focuses on curing tinnitus through the development of resources that advance tinnitus research. Founded in 1971, ATA is the only member- based and supported, national non-profit organization, dedicated to finding a cure for tinnitus. Since 1980 we have funded grants toward better understanding the mechanisms responsible for and underlying the genesis of tinnitus. Our Scientific Advisory Committee, comprised of 17 tinnitus investigators from multiple disciplines across the U.S., conduct peer reviews of all the grant proposals received at ATA. The most meritorious proposals with promise to help us get to that cure, are then forwarded to members of our Board of Directors who make the final funding decisions on these grants.

The advances in tinnitus research over the past decade have been extraordinary. Many researchers across the country are breaking down barriers as I speak, in their own laboratories. One of the most important advances through research in recent years is the ability to "visualize" tinnitus, through the use of advanced functional imaging technologies and through the development of animal models that can behaviorally assess the presence of tinnitus. These methods allow us to pinpoint tinnitus to certain regions of the brain. Another important advancement that has

occurred mainly through the use of animal models is the discovery that tinnitus is a result of brain plasticity that occurs in response to outside insults such as noise damage or head and neck injury. In layman's terms, brain plasticity refers to the ability of neurons in the brain to change their responsiveness and connectivity in the face of environmental influences. These developments have led the scientific community to understand that tinnitus is a disorder of brain function.

For decades, tinnitus was thought of as a disease of the ear, or simply a symptom of hearing loss. Because of research we now know that in most instances, tinnitus does not originate in the ear but rather in the brain. And we also know that you do not need to have a measurable hearing loss in order to have tinnitus. While noise overexposure is still the number one cause of tinnitus, it can also develop in the absence of hearing damage as the result of a head or neck injury. So, while the relationship between hearing loss and tinnitus is high, we still do not understand well why some people with hearing loss develop tinnitus and others do not. This is an important area of research for both human and animal models because if we understand why certain vulnerabilities exist, we can come up with more appropriate treatments.

Tinnitus also does not discriminate. It can happen to anyone at any time. 50 million Americans experience tinnitus and of those, 16 million seek medical attention for recurrent or chronic tinnitus. Two to three million are completely debilitated from their tinnitus rendering them unable to work, interact with family and friends, or sometimes even leave their home, degrading their quality of life. In addition to tinnitus, these people often have feelings of anxiety, depression and loneliness which can be directly attributed to their condition. Research has uncovered that depression and anxiety are comorbid conditions with tinnitus and may be part of the brain circuitry that is misdirected in bothersome tinnitus.

Specific groups of people are disproportionately impacted by tinnitus. These groups include, factory workers, police officers and firefighters, emergency medical technicians, musicians, and, the reason we are here today – our military personnel and veterans.

Tinnitus is the number one service-connected disability for returning veterans from Iraq and Afghanistan. As I mentioned before, in addition to hearing loss, head and neck injury can also contribute to tinnitus. So while tinnitus in these veterans is most often the result of extreme noise exposure from either a single impulse noise or the accumulation of noise exposure, head and neck injury is also a leading complaint of these veterans. In fact, lumbosacral or cervical strain account for 23% of service-connected disabilities for Iraq and Afghanistan veterans as of July 2009. In addition to factors that cause hearing loss, such as noise over-exposure, the generation and maintenance of tinnitus can occur as a result of temporal-mandibular joint disorder, or somatic insults, including lumbosacral or cervical strain. Research into how these systems interact in the brain has the potential to lead to treatments such as tailored devices that aim to ameliorate aberrant brain circuitries resulting from a combination of hearing loss and head and neck injuries.

Since 2006, service-connected disability payments to veterans from all periods of service for tinnitus, has been increasing at a rate of 15% per year. In 2012, the VA paid out $1.5 billion in disability compensation to over 971,000 veterans for tinnitus alone. At the current rate of increase the cost will exceed $3 billion annually by 2017. This dollar amount does not take into account the extreme suffering and necessary clinical care for veterans with tinnitus or the economic loss to society for those who are unable to work as a result of their tinnitus.

When you consider that cost, in comparison to what is being spent on tinnitus research in the U.S., there is a severe disconnect. Up until very recently the amount of money being spent on tinnitus research has been negligible. At the end of 2012, between all public and private funding in the U.S., approximately $10 million was spent on funding research toward a tinnitus cure. Though still a small number, this is up from a mere $1.5 million in 2005, and that increase has been all due to Congressional interest in this matter.

What have we learned as a result of recent increased research on tinnitus? And where do we need to go from here?

- It is now well-established that alterations in neural plasticity in distinct parts of the brain are changed in patient and animal models of tinnitus. This opens the way for stimulation treatments that alter the aberrant neural circuitry. Some examples of this are special devices that provide tailored auditory-somatosensory or vagal nerve stimulation with the aim of returning the circuits to a normal state.

- Other treatments aim to target changes in the molecular environment with targeted drug therapies but at present there is no drug treatment that is specific to tinnitus.
- The involvement of non-auditory systems in tinnitus is increasingly becoming apparent through animal and human tinnitus experimental models. Understanding these interactions in the brain is crucial for the development of treatments for alleviating this often debilitating condition.

Several studies have been conducted by both the Department of Defense and the Department of Veterans Affairs as a result of the growing need to address tinnitus in the military. Those studies directly connect tinnitus as co-morbidity to both Traumatic Brain injury and Post Traumatic Stress Disorder as well as indicate that tinnitus is a larger problem than hearing loss in the blast exposed population. This is why our organization has advocated for the inclusion of tinnitus as a research condition in tandem with both TBI and PTSD.

In particular, mild Traumatic Brain Injury or mTBI often includes tinnitus as a manifestation of injury. mTBI as defined by the Department of Defense Policy for Mild Traumatic Brain Injury is the presence of a documented head trauma or blast exposure event, followed by a change in mental status which could include nausea, dizziness/balance problems, temporary headache, sensitivity to noise or lights, vomiting, fatigue, insomnia and sleep disturbances, drowsiness, blurred vision, memory problems, poor concentration and tinnitus. A recent DoD study on Iraq veterans exposed to blast indicated that 70% of those exposed to blast reported tinnitus within the first 72 hours after the incident. 43% of those seen one-month after exposure to blast continued to report tinnitus. While the rate decreases over time, tinnitus rates exceeded hearing loss rates at all the time points. These findings also demonstrate the need for more comprehensive diagnostics and broader range of therapeutic approaches for tinnitus which can only be achieved by continued and additional research on the condition.

There have been some important bipartisan legislative steps taken by Congress in recent years to address the growing problem of tinnitus in veterans and active duty military personnel, including the addition of tinnitus as a researchable condition in the DoD Congressionally Directed Medical Research Program. The American Tinnitus Association applauds these efforts, and we very much appreciate the efforts of the Department of Veterans Affairs through the Portland VA Medical Center's National Center for Rehabilitative Auditory Research (NCRAR) to support tinnitus treatment. At the same time, we respectfully believe that tinnitus, which is so often associated with both TBI and PTSD deserves additional scrutiny. Improving tinnitus treatment with the goal of curing this disorder will almost assuredly impact treatment modalities for these other invisible wounds of war.

Through passage of legislation such as H.R. 1443, the lives of veterans will be improved. And every research dollar spent, each discovery, and every step toward a cure for tinnitus benefits all Americans who suffer with this disorder."

I would like to close by sharing with you an email (one of hundreds I receive) that exemplifies the impact of research in the life of a veteran:

"Dear Dr. Shore

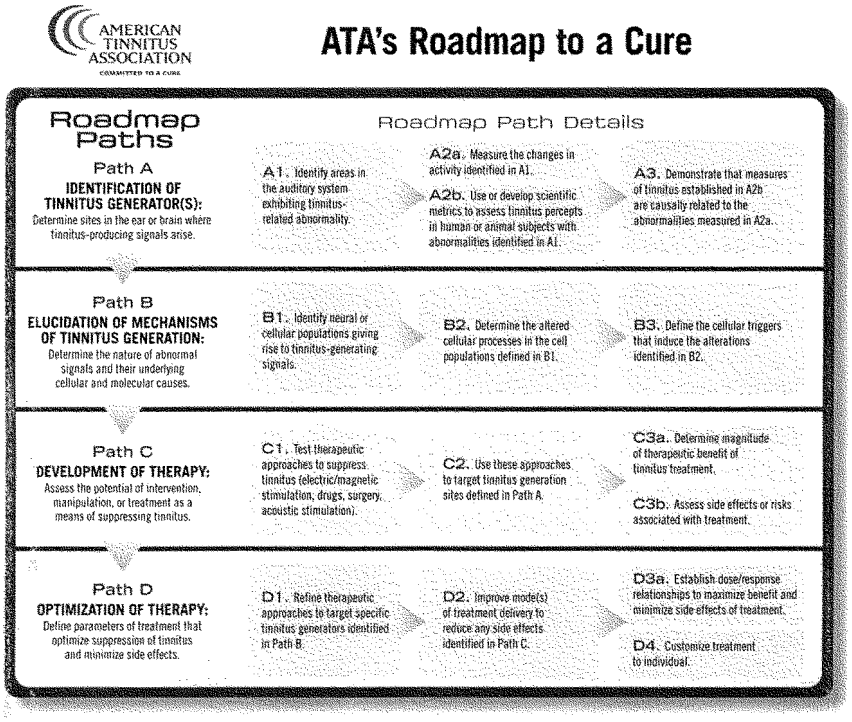
Like many vets I have suffered from tinnitus ever since I was exposed through my line of work during the four years I served in the USAF servicing F–4 Phantom Jets from 1966 to 1970. They had massive engines running nearby and ear protection was often lacking or in need of repair. My ears would often ring after work but after a few years began to ring more often until, as now, they ring 24–7. It is now to the point of changing much of my life through constant use of masking devices, insomnia and general aggravation. The VA will sometimes allow a very small 10% disability for tinnitus but has made it very difficult and time consuming to all but those who can afford an attorney to represent them. That level of disability amounts to a small pittance of about 100 bucks a month but can be helpful with hearing aids later in life.

However, I did file a claim with the VA which after many, many months was denied, the reason being according to their reviewing officer is that although I have some reduction in hearing (and had a reduction from my initial entrance to my discharge exam) it's not enough under VA standards PLUS they stand by statement quoted from and publication called the NOISE MANUAL (Fifth Edition, Berger, AIHA Press 2000, P125) "only seldom does noise cause a permanent tinnitus without also causing hearing loss". Aside from the fact that "hearing loss" is an arbitrary term and by the VA standard I have none, I am living proof that this statement is not always true and is not a valid criteria for denial of claims. Thank you greatly for your time and for your research into what has become for me a lifelong constant aggravation.

Yours sincerely, DCS"

This patient is correct in that tinnitus does not always have to occur in the presence of hearing loss detectable by conventional clinical methods. However recent research has indicated that more extensive hearing tests than are performed in the clinic may unveil hidden abnormality in the auditory system that may contribute to the brain plasticity underlying tinnitus. Even conventional hearing tests indicate that up to 19% of adolescents in the United States show evidence of mild hearing impairment caused by exposure to loud environmental and recreational sounds. Because peripheral hearing damage tends to worsen over the years, tinnitus is a looming public health challenge for citizens of all ages as well as a major disability affecting thousands of veterans in our armed forces.

Thank you again for the opportunity to be here and bring attention to tinnitus, a condition that has been far too long neglected. Passage of legislation such as H.R. 1443 will go a long way to helping us achieve our goals of improving tinnitus treatment and ultimately, finding a cure for this disorder. ATA is happy to provide any additional technical information on existing tinnitus research efforts as well as our suggestions for future activities, as embodied in the ATA "Roadmap" which is included as an addendum to my testimony.



Prepared Statement of Adrian M. Atizado

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

On behalf of the DAV (Disabled American Veterans) and our 1.2 million members, all of whom are wartime wounded and injured veterans, I am pleased to present our views on legislative measures that are the focus of the Subcommittee today.

Draft Bill, the Long Term Care Veterans Choice Act

Many veterans who are disabled due to complex, chronic disease or traumatic injury may be unable to live safely and independently, or may have health care needs that exceed the capabilities of their families. While many of these veterans are placed in nursing homes, others can remain in their community of choice with proper support, delaying or avoiding nursing home care. Since 1951, the VA's Community Residential Care (CRC) Program has provided health care and sheltered supervision to many of these veterans. This program has evolved through the years to encompass Psychiatric CRC Home, Assisted Living, Personal Care Home, Family Care Home, and Medical Foster Home (MFH).

Established in 2000, VA's Medical Foster Home (MFH) program currently operates under the same authority[1] as the CRC program. A type of community residential care facility limited to no more than three eligible[2] veteran residents in a private home, caregiver support is provided by the MFH attendant, and health care supervision is provided through VA's Home-Based Primary Care program or VA spinal cord injury home care program.

Patient participation in the MFH program is voluntary and veteran residents report very high satisfaction ratings. Furthermore, the administrative costs for VHA are less than $10 per day, and the cost of Home Based Primary Care, medications and supplies averages less than $50 per day. VA perceives this program as a cost-effective alternative to nursing home placement, and it is gaining popularity as evidenced by the program's expansion at the initiative of local VA providers with support from local VA facility leadership and VA Central Office.

However, because MHF operates under the CRC authority, participating veterans must pay the MFH caregiver approximately $1,500 to $4,000 per month for room and board, 24-hour supervision, assistance with medications, and whatever personal care may be needed.[3] Even veterans, who are otherwise entitled to nursing home care fully reimbursed by VA under the Veterans Millennium Health Care and Benefits Act (Millennium Act)[4] or under VA's policy on nursing home eligibility,[5] must pay to live independently in a CRC or MFH.

Were it not for the MFH program, veterans who meet the nursing home level of care standards would qualify for VA paid care to receive it at a significant cost to the Department. In addition, veterans who do not have the resources to personally pay for room, board, and caregiver services are not able to avail themselves of this benefit.

DAV is pleased with VA's innovation by offering the MFH program as part of its long-term services and supports (LTSS) portfolio, and we applaud the intent of this draft legislation to give VA authority to enter into an agreement or contract with or a VA approved MFH and pay for room, board, and caregiver services of veterans already eligible for VA paid nursing home care.

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[1] 38, United States Code § 1730.

[2] (1) The veteran is unable to live independently safely or is in need of nursing home level care; (2) The veteran must be enrolled in, or agree to be enrolled in, either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program, or a similar VA interdisciplinary program designed to assist medically complex veterans living in the home; and (3) The medical foster home has been approved in accordance with 38 C.F.R. § 17.73(d).

[3] 38 U.S.C. § 1730(a)(3).

[4] P.L. 106–117, 113 Stat. 1545 (1999) required that through December 31, 2003, VA provide nursing home care to those veterans with a service-connected disability rated at 70 percent or greater, those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent or greater, and those who were admitted to VA nursing homes on or before the effective date of the act. Subsequent law extended these provisions.

[5] VA's policy on nursing home eligibility required that VISNs provide nursing home care to veterans with 60 percent service-connected disability ratings who are also classified as unemployable or permanent and total disabled.

Accordingly, we support this draft measure based on DAV National Resolution No. 214, calling for legislation to expand the comprehensive program of LTSS for service-connected disabled veterans regardless of their disability ratings.

Mr. Chairman, DAV believes favorable consideration of this draft bill is a good first step for this subcommittee to assist VA in its effort to "rebalance" its LTSS portfolio. VA is and will continue to be challenged in providing appropriate LTSS due to the diversity, increasing number, and medical complexity of the veteran population who will need these services.

Research on consumer preferences and well-being—together with the 1999 Olmstead decision in which the Supreme Court upheld an individual's right to receive services "in the most integrated setting appropriate"—has motivated states to pursue rebalancing initiatives to shift LTSS systems away from institutional care and toward a system that embraces consumer choice and care in the home or community, and to reduce cost. The federal government's most recent commitment to rebalancing is found in numerous provisions in the Patient Protection and Affordable Care Act, where new authorities offer financial incentives to states to shift rebalancing efforts to the next level in order to continue to transform the LTSS system.

Though concern about the financing and delivery of LTSS is a recurring issue among policymakers, states have utilized a variety of innovative programs and services to rebalance their LTSS services, and spending for Medicaid Home and Community-Based Services (HCBS) has increased, accounting for 45 percent of total Medicaid long-term care services in 2010, up from just 13 percent in 1995. [6]

Today, VA lags behind States in offering and providing HCBS. The proportion of VA LTSS expenditures devoted to HCBS is little more than 20 percent for FY 2012. Oversight by this Subcommittee is sorely needed as VA endeavors to shift resources from nursing home care to more cost effective HCBS in order to serve more veterans while honoring their preferences. We urge is subcommittee to ensure VA HCBS innovations are not stifled and VA LTSS encompass a broad range of assistance to veterans regardless of age who have lost the ability to function independently thus preventing them to be active participants in their community.

H.R. 1443, the Tinnitus Research and Treatment Act of 2013

If enacted this bill would require VA to recognize tinnitus as a "mandatory condition" for purposes of research and treatment, led by VA's Auditory Centers of Excellence. The bill also would specify and define such research to include various assessments and studies of the condition of tinnitus. Finally, the bill would require cooperation between VA and the Department of Defense Hearing Center of Excellence with respect to tinnitus.

Despite tinnitus being the top service-connected condition in the veteran population today, our members have not approved a DAV national resolution specific to research about, or treatment of, the condition. However, as a partner organization of the *Independent Budget* for Fiscal Year 2014, DAV believes that nothing should be permitted to interfere with the scientific merit review process within the VA's research program, whether for tinnitus or for any other particular condition, disease, illness or injury.

While we are sensitive to the sponsor's expression of need for more research into tinnitus, as we would be for any condition endemic in the veteran population, as we indicated in the *Independent Budget*, "Ultimately, scientific merit based on careful peer review must be the determining factor in whether a [VA research] project is funded, not pressure from interest groups or interference in the selection of peer reviewers. The IBVSOs [*Independent Budget* veterans service organizations] and FOVA [Friends of VA Medical Care and Health Research, a 60-organization coalition] contend that between VA's current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. The *Independent Budget* veterans service organizations urge Congress and VA to take assertive steps to preserve and protect the quality and transparency of VA's research funding decisions."

On the basis of these concerns, expressed collectively by DAV, AMVETS, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States, we believe the purpose and requirements imposed by this bill should be reconsidered by its sponsor.

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[6] Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long-Term Care Services and Supports." 2012. Available at *http://www.kff.org/medicaid/upload/2186-09.pdf*.

H.R. 1612, to direct the Secretary of Veterans Affairs to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University, and for other purposes

This bill would require the VA to convey 64.5 acres of the present VA Medical Center in Tuskegee, Alabama, comprising 20 structures, to the Tuskegee University, for the university's purposes.

We have received no resolution on this specific matter from our members, and thus, DAV takes no position on this legislation.

H.R. 1702, Veterans Transportation Service Act

This bill would provide VA a renewed authority to transport individuals in connection with their vocational rehabilitation, counseling, examination, treatment, or care, and make permanent an important transportation program after only one year of life.

Notably, VA has implemented the provisions of Section 202 of Public Law 112–260, the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012, except for eliminating the authority granted under Section 111A of title 38, United States Code, to create a VA-operated transportation program one year after enactment. That act had prompted VA to initiate the Veterans Transportation Service (VTS), supported by the Veterans Health Administration (VHA) Chief Business Office (CBO). The VTS was established to provide veterans with convenient and timely access to transportation services and to overcome access barriers certain veterans may have experienced, and in particular to increase transportation options for veterans who need specialized forms of transportation to VA facilities. The VTS transportation services to VA medical centers include the use of technology and mobility management training for medical center staff that in turn enable VTS services to better interface with other community transportation resources.

VA medical centers and sites where VTS is operating can be ideal partners with the DAV National Transportation Network and for the Veterans Transportation and Community Living Initiative grant projects establishing One-Call/One-Click Transportation Resource Centers. Based on our review of this situation, were it not for the expiration of statutory authority from Public Law 112–260, VTS would have grown from its current 45 sites to all remaining VA locations by 2015.

The DAV National Transportation Network continues to show tremendous growth as an indispensable resource for veterans. Across the nation, DAV Hospital Service Coordinators operate 200 active programs. They have recruited 9,249 volunteer drivers who logged over 27 million miles last year, providing almost 721,000 rides for veterans to and from VA health care facilities. These veterans rode in vans DAV purchased and donated to VA health care facilities for use in the DAV National Transportation Network. DAV Departments and Chapters, together with our national organization, have now donated 2,586 vans to VA health care centers nationwide at a cost to DAV of $56.7 million.

DAV believes VTS serves the transportation needs of a special subset of the veteran patient population that the DAV National Transportation Network is unable to serve—veterans in need of special modes of transportation due to certain severe disabilities. We believe that with a truly collaborative relationship, the DAV National Transportation Network and VTS will meet the growing transportation needs of ill and injured veterans in a cost-effective manner.

Currently, DAV supports enactment of this bill; however, our support is based on the progress gained through our collaborative working relationship with VHA and CBO to resolve weaknesses we have observed in the VTS program. As you may be aware, VTS operates with resources that would otherwise go to direct medical care and services for veterans. These resources should be used carefully for all extraneous programs to ensure veterans are not denied care when they most need it.

We thank VHA and CBO for their commitment and continuing efforts in working with DAV to ensure VTS will indeed work in concert with all existing and emerging transportation resources for veterans who need VA care, and to guard against fraud, waste and abuse of these limited resources.

We look forward to continuing our work with the Committee on this measure, and to work for its passage.

H.R. 2065, Safe Housing for Homeless Veterans Act

The Safe Housing for Homeless Veterans Act would amend Title 38, United States Code, to require entities that receive per diem payments through the Department of Veterans Affairs (VA), for the provision of services to homeless veterans, to submit an annual certification to the Secretary of Veterans Affairs proving that the

building where the entity provides housing or services is in compliance with codes relevant to the operations and level of care provided.

The certification would include compliance with requirements outlined in the recently published version of the Life Safety Code, International Building Code and International Fire Code, or similar codes that have been adopted as State or local codes in the jurisdiction of the project. In addition, all licensing requirements regarding the condition of the structure and the operation of supportive housing or service center, including fire and safety requirements, must be provided.

For entities that receive per diem payments during the year in which the legislation is enacted, the recipient must submit all certifications required no later than two years after the date of enactment to the Secretary, or additional per diem payments will be halted until certification is received.

DAV previously testified on a similar bill, H.R. 4079 introduced in the 112th Congress, that while we did not have a National Resolution from our membership specifically covering the state of the housing provided to veterans or the safety of the facilities where homeless services are provided, we did not oppose favorable consideration of the legislation. Since that hearing, it has been brought to our attention that the requirements outlined in H.R. 2065 may adversely impact Grant and Per Diem providers, which could leave many homeless veterans and their family without the services they need.

While DAV agrees with the intent of the measure to provide safe shelters for our homeless veterans, we urge the Subcommittee work with VA and Homeless Grant and Per Diem providers, to mitigate any detrimental effects this bill may have while meeting the needs of homeless veterans in a safe environment.

DAV appreciates the opportunity to submit our views on the legislative measures under consideration at this hearing. This concludes my testimony, Mr. Chairman. I would be pleased to answer any questions related to my statement and the views I have expressed on behalf of DAV.

Prepared Statement of Robert Drexler

Good morning, Mr. Chairman, and distinguished Members of the Subcommittee. My name is Robert Drexler, Member of the Board of Directors of the International Code Council. I also serve as Fire Marshal for the town of Greece, New York . I am pleased to be here to discuss the importance of compliance with building and fire codes, speaking on behalf of the over fifty thousand building, fire code officials and other professionals across the United States who are the members of the Code Council.

The Code Council was formed in 1994 as a nonprofit organization dedicated to developing a single set of comprehensive and coordinated national model construction codes. The founders of the ICC were the Building Officials and Code Administrators International, Inc. (BOCA), International Conference of Building Officials (ICBO), and Southern Building Code Congress International, Inc. (SBCCI). Since the early 1900s, these nonprofit organizations developed three separate sets of regional model codes used throughout the United States. We joined these three groups together, and published a single code for the United States- the International Codes- beginning in 2000. In 2003, the International Code Council became the successor organization to the three legacy code groups, and so we are celebrating our tenth anniversary as an organization in 2013.

Today our International Model Codes have been adopted at the state or local level in all 50 states and the District of Columbia. Numerous federal agencies, including the General Services Administration, the Department of Defense and the Architect of the Capitol have implemented the I–Codes, as have Puerto Rico and the U.S. Virgin Islands. The Code Council's 50,000 members and over 300 chapters include state, county and municipal code enforcement and fire officials, architects, engineers, builders, contractors, elected officials, manufacturers and other construction industry professionals.

I come before you today to encourage support for HR 2065, the Safe Housing for Homeless Veterans Act, sponsored by Rep. David McKinley of West Virginia and Rep. Grace Napolitano of California. Those of us who work in the realm of building safety at both the state and local level appreciate the concern that this bill has for the welfare of our veterans, who are living in housing subsidized by the Department of Veterans Affairs.

In the building sector, the International Residential Code, the International Building Code, and the International Fire Code establish the basic requirements for building safety at the time of construction, and in the case of the Fire Code, at the

time of the annual inspection. These codes do not guarantee that a building will be safe from any and all hazards, as destructive forces can bring down any building if enough force is applied. But the codes do assure that when faced with the typical hazards that buildings are expected to encounter, including fire, windstorm, flooding, and even normal or even somewhat careless daily use, the building will allow for building residents and users to survive, and for first responders to safely rescue building occupants, and minimize property damage.

In most jurisdictions around the country, either at the state level, or at the local jurisdictional level, both the International Building Code (IBC) and the International Fire Code (IFC) assure that buildings used for residential care and housing are safe. Our local code officials around the country inspect veterans' homes and assure that they meet currently adopted codes, just as they do other commercial buildings. This is true in California, as well as 42 other states that have adopted both the IBC and the IFC. In fact all 50 states have adopted the IBC at either the state or local level, and 43 states adopt the IFC, while a significant number also adopt the Life Safety Code(LSC), at either the state or local level.

HR 2065 wisely does not attempt to mandate one code or the other for compliance by facilities approved by the Department of Veterans Affairs for reimbursement, but requires a certification from all homes that they meet either the IBC and IFC, or the LSC, which are functionally, and from a safety standpoint, equivalent code requirements.

In addition, the bill does not impose any onerous administrative burden on the Department of Veterans Affairs, other than to assure that each facility receiving reimbursement has filed a certification, either from the local code official, or from a competent third party, that code requirements are met. This is a reasonable and very workable requirement that mirrors similar requirements in place for other medical facilities that must provide very similar assurances to the Centers for Medicaid and Medicare (CMS), in the Department of Health and Human Services.

It is true that for veterans' homes covered by this requirement that are located in a jurisdiction that does not adopt and enforce either the IFC or LSC, there will be a small additional burden of obtaining an annual inspection to show compliance with the relevant code provisions. However, it is the clear intent of the bill sponsors, and a worthy goal in our opinion, that the safety of our veterans, who sacrificed so much for our freedoms, should be provided with safe housing, especially when the taxpayer is subsidizing that housing. It's hard to argue that our veterans should not be assured of minimal safety in their housing, when the cost of assuring safety is a few hundred dollars or less.

In closing, the International Code Council is proud of our work in developing the model codes used by most jurisdictions to assure a basic level of safety in the built environment, and we applaud your efforts to use those codes to protect the safety of our veterans. We continue to work to update and improve the codes, issuing revised codes every three years, through our governmental consensus process for the regulation of building construction. I applaud the work of your Subcommittee and encourage continued collaboration between the public and private sectors to achieve the important goal of increased safety in our nation's buildings. Thank you again for the opportunity to appear before you today. I will gladly answer any questions.

Prepared Statement of Raymond C. Kelley

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to offer testimony on today's pending legislation.

H.R. 1443, the Tinnitus Research and Treatment Act of 2013

The VFW supports this legislation which would require the Department of Veterans Affairs (VA) to recognize tinnitus as a mandatory condition for research and treatment by the VA Auditory Centers of Excellence in cooperation with the Department of Defense Hearing Center of Excellence. Characterized by a steady or intermittent ringing of the ears, tinnitus can cause sleep disruption, cognitive impairment and employment difficulties, and can worsen the symptoms of depression and anxiety disorders. Tinnitus is the most frequent service-connected disability awarded by VA among veterans of all eras. The common causes of tinnitus are acoustic trauma and traumatic brain injury, placing Iraq and Afghanistan veterans at particularly high risk due to IED blast exposure. Since 2000, the number of veterans

who are service-connected for tinnitus has increased by at least 16.5 percent each year.

Although there is no known cure for tinnitus, it should not be assumed that the condition is untreatable. VA's Progressive Tinnitus Management approach, which assists tinnitus suffers through individual counseling and support, is helping veterans better manage their symptoms. Still, more research is needed in order to identify truly effective treatments to alleviate those symptoms. This bill represents a positive first step towards achieving that goal.

H.R. 1612, to direct the Secretary of Veterans Affairs to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University.

The VFW supports H.R. 1612, a bill that directs the Secretary of VA to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University. More than 90 years ago, Tuskegee University, a land grant university, voted to donate 300 acres of land so the United States government could build a veterans hospital. Today, 21 of the buildings, accounting for nearly 280,000 square feet of space, sit vacant on that property. Nearly half of the buildings that would accompany the transfer are former quarters for employees who worked in housekeeping within the hospital, while several others are small 500 square feet or less storage buildings.

Annually, VA spends approximately $2 per square foot to maintain vacant space. For the buildings that fall within this land transfer, VA spends more than $500,000 per year in maintenance. Reducing the financial burden for upkeep of these buildings and grounds will allow VA to better use those non-recurring maintenance funds to ensure the highest level of maintenance for the facilities that provide care and service to our veterans and not on buildings that are sitting vacant.

With nearly 1000 vacant or underutilized buildings within their system, the VA must work to right-size its property inventory, decreasing its footprint in some areas and increasing it in others. In doing so, VA must ensure they can provide a full continuum of care for veterans. At the Tuskegee VA Campus, programs and services have been expanded to include homeless shelters, community living facilities and women veterans services. Knowing VA has utilized as much of the property as possible, it is a financially responsible decision to return 64.5 acres of the original 300 acres land and improvements back to Tuskegee University.

H.R. 1702, the Veterans Transportation Service Act

The VFW supports this legislation to permanently authorize the Veterans Transportation Service (VTS). This program, commissioned by the VHA Office of Rural Health in 2010, has greatly improved access to care for rural and seriously disabled veterans by allowing VA facilities to establish and coordinate networks of local transportation providers, including community and commercial transportation providers, and government transportation services. The VTS augments veterans service organizations' volunteer-based transportation services, which are limited to transporting ambulatory veterans, and supplements the existing beneficiary travel programs of mileage reimbursement, which does not provide assistance with the coordination of transportation for those who need it, and special mode travel, for which few veterans medically qualify.

The VTS suffered a major setback in 2012 when it was temporarily suspended following a determination by the VA Office of General Counsel that VA lacked the statutory authority to hire paid drivers to transport veterans. Congress wisely passed a one-year authorization of the VTS program in January 2013, but a long-term fix is still needed.

The VFW believes that unnecessary hardships associated with accessing VA health care should be eliminated at every opportunity. This legislation would guarantee the continuation and future expansion of VTS, which plays a critical role in minimizing the challenges many veterans face in traveling to their appointments due to physical disabilities or great distances.

H.R. 2065, the Safe Housing for Homeless Veterans Act

The VFW supports this legislation which would require facilities that house homeless veterans to meet all relevant local building codes in order to receive per diem payments under the VA Homeless Providers Grant Per Diem Program. Currently, VA is required to check housing certificates before awarding grants for housing services provided to homeless veterans. However, thorough checks of fire and safety requirements, as well as structural conditions of the building, are often overlooked. The bill requires that current recipients of per diem payments submit certification

of compliance with local codes within two years of the enactment of this act, giving them ample time to make any necessary improvements.

The VFW believes that VA funded transitional housing must be safe, secure, and sanitary. This bill would ensure that those standards are met, providing homeless veterans with the best chances of successful community reintegration.

Draft Bill, the Long-Term Care Veterans Choice Act

The VFW supports this legislation, which would add language to Section 1720 of Title 38 to allow veterans who receive VA care and require a protracted period of nursing home care to transfer into an adult foster home at their request. Under the bill, such homes must be "designed to provide non-institutional, long-term, supportive care for veterans who are unable to live independently and prefer a family setting." VA currently has the authority to reimburse institutional care facilities such as nursing homes for long-term domiciliary care, but veterans who choose to live in adult foster homes must do so at their own expense. To grant VA the authority to reimburse adult foster homes would provide veterans with an additional residency choice, potentially improving the quality of life for those who would prefer this option.

The VFW strongly believes that all non-VA services should be provided in conjunction with proper care coordination. VA Handbook 1141.02, Medical Foster Home Procedures, establishes the policies and standards of VA care coordination for veterans who choose to live in medical foster home settings. It requires an interdisciplinary VA Home Care Team to provide the veteran with primary care, regularly communicate with the foster home caregiver, and monitor the care provided by the foster home with frequent unannounced visits. The VFW feels that these would ensure adequate care coordination for veterans who chose to participate in a fully-funded adult foster care program. VA Handbook 1411.02 is scheduled for recertification in 2014, and the VFW recommends that the care coordination policies outlined in that document should be made permanent by adding them to the language of this legislation.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you or other Members of the Committee may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

Prepared Statement of Robert L. Jesse

Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

We do not yet have cleared views on H.R. 1612, a bill that would direct VA to convey a parcel of land to Tuskegee University. We will forward views and any estimated costs to you as soon as they are available.

H.R. 1443 Tinnitus Research and Treatment Act of 2013

Section 2 of H.R. 1443 would require VA to recognize tinnitus as a mandatory condition for research and treatment by VA Auditory Centers of Excellence. Section 3 of the bill would require the Secretary to ensure that research on the prevention and treatment of tinnitus is conducted at VA facilities. Required research would include an assessment of the efficacy of multidisciplinary tinnitus treatment modalities on different subsets of patients; studies on the underlying etiology of tinnitus in Veteran populations that occur as a result of different causal factors, including blast-related tinnitus, where there is no measurable hearing loss, versus other forms of noise-induced tinnitus, where there is hearing loss; and a study of the underlying mechanisms between hearing loss and tinnitus, including cases in which one or the other condition is present, but not both. VA would be required to ensure VA cooperation with the Hearing Center of Excellence established by the Department of Defense (DoD) to perform further research on tinnitus.

This bill appears to be consistent with existing programs and operations within the Veterans Health Administration. Therefore, we do not believe this legislation is necessary.

VA Audiology Clinics currently provide tinnitus treatment through VA's Progressive Tinnitus Management Program, a five-level program that provides education and treatment services to Veterans tailored to the degree of the disabling effects of tinnitus. Basic tinnitus intervention involves group educational counseling focused on providing Veterans with the knowledge and skills to self-manage their tinnitus. This group counseling involves interdisciplinary collaboration between audiology and psychology. For those Veterans who do not obtain relief from hearing aids or group educational counseling, VA offers treatment, including a comprehensive assessment and individualized counseling. If none of the above services are beneficial, VA begins treatment involving individualized management including relaxation techniques, cognitive behavioral therapy, drug therapy, sound-based therapy, and combined techniques. VA has also developed patient education materials and clinical training materials to advise clinicians on how best to identify, diagnose, and treat tinnitus and other auditory conditions.

VA's National Center for Rehabilitative Auditory Research (NCRAR), a VA Rehabilitation Research and Development Center of Excellence, has active research projects underway on the efficacy of multidisciplinary tinnitus treatment (e.g., Progressive Tinnitus Management) as referenced in Subsection (1) of Section 3 of the bill. NCRAR is also collaborating with the VA Audiology Program to develop and evaluate Progressive Tinnitus Management at VA medical centers.

VA has active research projects underway addressing the underlying etiology of tinnitus, as well as the mechanisms underlying the co-occurrence of hearing loss and tinnitus, as referenced in Subsections (2) and (3) of Section 3.

VA is also collaborating with DoD on the development of the Defense Center of Excellence for Hearing Loss and Auditory System Injuries, as mandated by Congress in section 721 of Public Law 110–417. The Center will develop a registry of information to track the diagnosis, surgical intervention, or other operative procedure, or treatment, and follow up for each case of hearing loss and auditory system injury incurred by Servicemembers while on active duty. This registry will also facilitate an electronic data exchange with VA. The law further requires the Center to collaborate with NCRAR and VA to ensure coordination of ongoing auditory system rehabilitation benefits and services by VA.

VA believes that implementation of H.R. 1443 would be cost-neutral, if enacted, because VA already complies with the provisions of the bill.

H.R. 1702 Veterans Transportation Service Act

VA supports this legislation which would permanently extend the Secretary's authority to hire qualified drivers to transport any person to or from a Department facility or other place in connection with vocational rehabilitation or counseling required by the Secretary pursuant to chapter 34 or 35 of title 38, or for the purpose of examination, treatment, or care. The Veterans Transportation Service (VTS) depends on paid drivers to provide transportation services. Section 111A of title 38 of the United States Code (U.S.C.) currently provides authority for use of paid drivers until January 9, 2014.

Through the VTS program, VA provides funding to local VA facilities for mobility managers, transportation coordinators, and vehicles to complement the existing services that volunteers already provide. The service provides Veterans with transportation to and from their VA health care appointments, improving both access to care and continuity of care for many who would otherwise be limited in mobility. In 2012, VTS provided Veterans with more than 199,000 one-way trips totaling more than 9.7 million miles. The average length of a one-way trip is over 48 miles—a considerable distance and a prohibitive one for those with poor health if transportation were not available. Veterans with prostheses or those who use wheelchairs have particularly benefited from the VTS program.

Veterans Service Organizations such as Disabled American Veterans are invaluable in providing volunteers for VA's Volunteer Transportation Network. However, with increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers in all regions of the country to serve the level of need. Furthermore, volunteer drivers are generally precluded from transporting Veterans who are not ambulatory, require portable oxygen, have undergone a procedure involving sedation, or have other clinical issues. Some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. Without paid drivers, many Veterans would not have transportation to get to their medical appointments to receive the care they need.

VA was grateful for enactment of the temporary authority to ensure we could continue to use paid drivers in the VTS program. The temporary nature of the authority, however, has impacted expansion of VTS, as VA facilities have been cautious in adding staff in light of the expiration that would occur early next year without

legislative action. This has understandably dampened our ability to expand the program. Permanent authority will provide this beneficial program with the stable foundation it merits.

VA is unable to provide an accurate estimate of the cost savings associated with this bill at this time. However, since VTS became operational, savings have resulted from the use of paid VA drivers over Beneficiary Travel Special Mode transportation. VA paid drivers are a less expensive option than Special Mode transport. VA is closely examining the cost data across locations where VTS is implemented and will provide this information for the record as soon as we are able.

H.R. 2065 Safe Housing for Homeless Veterans Act

H.R. 2065 would amend 38 U.S.C. 2012(c)(1), which requires that Grant and Per Diem (GPD) grantees or eligible entities comply with specified fire and safety rules. In place of the current section 2012(c)(1), H.R. 2065 would impose a new requirement that would limit per diem payments to grant recipients or eligible entities who submit an annual certification (that has been approved or verified by the "authority having jurisdiction or a qualified third party") that the building where the entity provides housing or services is in compliance with codes "relevant to the operations and level of care provided."

VA does not support H.R. 2065. We are concerned it would fundamentally shift VA's role in inspecting and overseeing GPD facilities and would shift some of the costs of facility inspections from VA to the GPD grantee. Currently, VA ensures that GPD facilities meet the requirements of the Life Safety Code (LSC) of the National Fire Protection Association through on-site inspections of each facility by staff from the local VA medical center. The inspection team includes representatives from the local VA medical center, who are responsible for ensuring that general operating requirements as noted in GPD regulations are met. The inspection team members are responsible for the review of the project in the following areas: clinical, facilities management, security/law enforcement, and nutrition and food services. The facilities management portion of the inspection includes a requirement for VA staff to evaluate compliance with the LSC. These projects must pass an initial inspection prior to per diem being awarded. Any deficiencies (e.g., nutrition, security, clinical, safety) noted by the inspection team must be corrected by the GPD-funded organization before the project can become operational. A completed initial inspection is signed by the VA medical center Director, approving the placement of Veterans within the project. The inspection packet is then reviewed by the Veterans Integrated Service Network (VISN) Homeless Coordinator for completeness and sent to the GPD National Program Office. GPD providers are also subject to annual re-inspection. The annual inspections are conducted in the same manner as the initial inspection. VA is concerned that merely requiring a certification of compliance with the LSC would remove an essential component of VA's GPD facility inspection process making homeless Veteran transitional housing less safe and secure.

Presently, the cost of inspecting a GPD facility for compliance of the LSC currently falls on VA. Ostensibly, section 2(a)(1) of H.R. 2065 would shift the cost of LSC compliance to the GPD provider. Because section 2(a)(1) merely specifies that the annual certification must be "approved or verified by the authority having jurisdiction or a qualified third party," the concern is that a GPD provider would receive certifications of compliance from individuals or entities who are not truly qualified to certify compliance. Under the current statute and regulations, VA officials inspect and determine whether GPD facilities comply with the LSC. VA inspectors are directly accountable to the Department, and there are no concerns about the suitability or qualifications of third parties providing "certifications." However, VA notes that many of the concerns addressed by section 2(a)(1) could be resolved through regulation.

Furthermore, VA does not agree with the suggestion in section 2(a)(1) that the "International Building Code and International Fire Code" are a suitable alternative to the LSC. VA is not aware of any single standard that is comparable to the LSC. The LSC is unique in that it is organized with chapters that address each occupancy type, has specific infrastructure requirements for existing as well as new facilities, and also provides operational requirements. The LSC accomplishes by itself what it would require multiple other codes to accomplish. For example, if the International Code Council (ICC) Family of codes was utilized, it would require use of the International Building Code, International Residential Code, International Fire Code, and International Existing Building Code in order to encompass the same scope as the LSC.

While a different set of standards (other than the LSC) could be utilized to provide a comparable set of fire and safety requirements, VA believes that introducing another set of codes and standards would not benefit Veterans or VA in any mate-

rial way. It would also not likely result in increasing the number of facilities that could be approved for the GPD program, and it could create an added burden for VA by potentially requiring VA staff to be trained on two sets of codes and standards instead of one.

It should also be noted that VA facilities receive accreditation from The Joint Commission, which requires compliance with the LSC. VA uses the LSC for all VA facilities (including accredited facilities) to establish consistency across the country for minimum life safety requirements, code interpretation, and fire safety training for VA staff. Finally, section 2(b)(2) could be an extremely burdensome and costly reporting requirement. Although section 2(b)(2) gives little guidance on the extent and scope of these reporting requirements, it requires an evaluation of all facilities receiving per diem payments. Since VA has an active and robust cadre of GPD Liaisons, individuals at the local VA medical center who liaise with GPD grantees and ensure compliance with inspection findings, VA does not believe these potentially burdensome reporting requirements are necessary.

If enacted, this bill would be cost neutral to VA; however the cost to VA's community-based providers could be substantial.

Draft bill entitled the "Long-Term Care Veterans Choice Act"

The draft bill would allow Veterans, for whom VA is required to provide nursing home care by law, to request a transfer to homes designed to provide non-institutional long-term supportive care for Veterans, who are unable to live independently and prefer to live in a family setting. VA would pay the expenses by a contract or agreement with the home. One condition upon the transfer would be the Veteran's agreement to accept home health care services furnished by VA.

VA supports the Medical Foster Home (MFH) concept, where eligible Veterans who would otherwise need nursing home care could get, when clinically appropriate, long-term care in a more personal home setting. VA endorsed this idea in its fiscal year 2014 budget submission. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. While endorsing the MFH concept, VA cannot today offer a complete evaluation of the text of the draft bill. We have been working with the Subcommittee on technical assistance and look forward to further discussion.

Mr. Chairman, thank you for the opportunity to present VA views on these bills, and we will be glad to answer any questions you or the other Members may have.

Statements For The Record

U.S. REP. RON BARBER

H.R. 1702 the Veterans Transportation Service Act

Mr. Chairman and Ranking Member Brownley, thank you for your leadership on this subcommittee, which is so vital to meeting the health care needs of America's veterans.

Thank you for the opportunity to attend this hearing and to offer testimony on H.R. 1702, the Veterans Transportation Service Act. I apologize that I cannot be here in person, as I am with the Arizona Congressional Delegation attending the funerals of nineteen firefighters who perished fighting the Yarnell Hill Fire.

Mr. Chairman, according to data provided by the Department of Veterans Affairs and Veterans Service Organizations, about six million veterans reside in rural areas of the United States.

Of these six million veterans, more than half are enrolled in the Department of Veterans Affairs healthcare system.

In my district alone, there are nearly ninety thousand veterans, many of whom live outside of the major cities in communities very far away from VA clinics or service centers. My office receives a significant number of calls every week from veterans who live in rural areas and who need medical services from the VA and for whom transportation is a major problem.

The stories that I hear from rural veterans are no different, I imagine, from those that you are hearing from veterans in your districts as well.

Those who live in rural areas are not the only veterans who need assistance. Thousands of veterans who live in the cities and towns across this nation need help with transportation as well.

In 2010, the Department of Veterans Affairs launched a Veterans Transportation Service (VTS) initiative to enhance transportation options for veterans who were seeking health care at VA facilities.

Through the Veterans Transportation Service, funding is provided to local VA facilities to hire transportation coordinators and purchase vehicles driven by VA-trained staff.

Over the course of the last two years, VTS has provided veterans with more than 199,000 trips to medical facilities, totaling more than 9.7 million miles in 37 states.

As you can tell from these numbers, this is a service that plays an important role in supporting our veterans. I believe we need to expand it so that we may assist transportation-disadvantaged veterans in other un-served or underserved areas of the country.

I have introduced H.R. 1702, along with my colleague and Vice Chairman of the House Armed Services Committee, Mac Thornberry, to enact a permanent reauthorization for the VTS service.

I would be remiss if I did not also mention the leadership provided by Senator Jon Tester on this issue as well; he is a champion in the Senate where this legislation also has strong bipartisan support.

Last year, the VA's Office of General Counsel raised questions as to whether the VA could hire drivers to operate the VTS without specific Congressional authorization. The program was discontinued as a direct function of the VA.

Luckily, with Senator Tester's leadership, the Congress moved quickly at the end of last year to provide the authorization needed to get the program back in operation.

That authorization will only run until the end of 2013.

Questions have been raised about the possibility of volunteers providing transportation.

We all appreciate the invaluable volunteer transportation assistance the Disabled American Veterans provide to veterans, but there are many veterans who need a service different from the one provided by the DAV. The VTS is therefore complementary, not competitive, to the DAV program.

VA Mobility Managers are trained to help make transportation decisions that are in the best interest of the veteran, often directing veterans to DAV services when appropriate and available.

VTS drivers operate Americans with Disabilities Act compliant wheelchair and stretcher vehicles.

For those veterans who are not ambulatory, who require portable oxygen, who have undergone a procedure involving sedation, or who have other clinical issues, these transportation services are critical to ensure their safe transportation to medical appointments and facilities.

One of the most important aspects of the Veterans Transportation Service Act is that it saves the taxpayers money.

The Department of Veterans Affairs has projected that they will save 19.2 million dollars in fiscal year 2014 alone by using the VTS for appropriate patients.

This legislation is estimated to save the VA over 100 million dollars in five years. This is money that could be well spent on other aspects of veteran care.

I believe HR 1702 is critical to the care of veterans in my Southern Arizona district and across this nation.

I urge the Committee to take up this needed legislation so that the VA can continue and expand the VTS program. Thank you again for the opportunity to present this testimony, and I look forward to answering your questions. Thank you.

NATIONAL ASSOCIATION OF STATE FIRE MARSHALS

Mr. Chairman and Honorable Members of the House Committee on Veterans' Affairs Subcommittee on Health, the National Association of State Fire Marshals (NASFM) is pleased to submit this statement for the record in support of HR 2065, the Safe Housing for Homeless Veterans Act. NASFM applauds Congressman McKinley's leadership on this issue.

NASFM's mission is to protect life, property and the environment from fire and related hazards. NASFM's members are the senior fire safety officials in the United States and the District of Columbia. State Fire Marshals' responsibilities vary from state to state, but most State Fire Marshals are responsible for fire safety code adoption and enforcement, fire and arson investigation, fire incident data reporting and analysis, public education and advising Governors and State Legislatures on fire protection matters. Some State Fire Marshals are responsible for fire fighter

training, hazardous materials incident responses, wildland fires and the regulation of natural gas and other pipelines.

In connection with their code adoption and enforcement responsibilities, State Fire Marshals care deeply that occupancies of all kinds meet minimum safety code requirements—particularly those in which groups of individuals, at least some of whom may be challenged physically, gather and spend the night. We have learned from HR 2065's sponsor, Congressman McKinley, that more than 67,000 veterans are homeless on any given night, and, over the course of a year, approximately twice that many experience homelessness. Just as our veterans helped to ensure the safety of Americans during their active service, the United States should do no less for them now, especially if they are experiencing the hardship of homelessness.

Without HR 2065, homeless veteran shelters are subject to whatever fire and building codes apply in their particular jurisdiction. In some places, the existing codes establish minimum requirements that are enforced. However, in some states, no minimum building or fire code requirements exist, except in the larger cities. And within states, code requirements can vary from jurisdiction to jurisdiction, as do the capabilities of code enforcement entities.

This is why it is crucial to include a provision in HR 2065 that would require any state or local code to provide an equivalent or higher level of safety than is provided by the Life Safety Code. According to the National Fire Protection Association, the scope of the Life Safety Code (also known as NFPA 101) is as follows: "The Code addresses those construction, protection, and occupancy features necessary to minimize danger to life from the effects of fire, including smoke, heat, and toxic gases created during a fire. The Code establishes minimum criteria for the design of egress facilities so as to allow prompt escape of occupants from buildings or, where desirable, into safe areas within buildings. The Code addresses other considerations that are essential to life safety in recognition of the fact that life safety is more than a matter of egress. The Code also addresses protective features and systems, building services, operating features, maintenance activities, and other provisions in recognition of the fact that achieving an acceptable degree of life safety depends on additional safeguards to provide adequate egress time or protection for people exposed to fire. The Code also addresses other considerations that, while important in fire conditions, provide an ongoing benefit in other conditions of use, including non-fire emergencies. The Code does not address . . . general fire prevention or building construction features that are normally a function of fire prevention codes and building codes."

NASFM believes that the Life Safety Code is an appropriate code to cite in HR 2065 for minimum safety criteria, because it not only contains both fire and building safety provisions, but it also addresses both new and existing buildings in the same code. Another Federal agency, the Centers for Medicare & Medicaid Services, requires compliance with the Life Safety Code by health care organizations in order to begin and continue participating in the Medicare and Medicaid programs, so there is precedence for its use in this situation. By referencing the most current edition of the Life Safety Code (the 2012 edition being the most recent), HR 2065 would help ensure that homeless veterans are protected with a consistent fire protection code if they are sheltered in occupancies that receive grants from the Secretary of Veterans Affairs, no matter where in the United States they may be.

Applicable provisions of the International Building Code and the International Fire Code – or the versions of those codes that have been adopted at the state or local levels by the jurisdiction in which the project is located – may be appropriately applied instead of the Life Safety Code, as long as they are demonstrated to provide equivalent or higher levels of safety than is provided by the Life Safety Code. We know from our discussions with Congressman McKinley's staff that this bill does not intend to preempt any state or local codes that may provide an equivalent or higher level of life safety than HR 2065 would provide. Fire and building safety codes are an intricate subject, to say the least. As the debate on HR 2065 continues, NASFM stands ready to work with the U.S. Congress and the U.S. Department of Veterans Affairs if questions arise regarding the implementation of the code-related provisions of this bill.

NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Dan Benishek, Ranking Member Julia Brownley, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health:

The National Coalition for Homeless Veterans (NCHV) is honored to present this Statement for the Record for the legislative hearing on July 9, 2013. On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your steadfast commitment to serving our nation's most vulnerable heroes.

This statement will focus on Rep. David McKinley's H.R. 2065, the "Safe Housing for Homeless Veterans Act." While we are appreciative of any effort to protect homeless veterans from unnecessary harm as they work to reintegrate into society, NCHV believes that this bill as currently written could adversely impact organizations that seek to serve those veterans. Therefore, NCHV does not support H.R. 2065 at this time.

Evolution of "Safe Housing" Legislation

The original "Safe Housing for Homeless Veterans Act," introduced in the second session of the 112th Congress by Rep. McKinley, would have required entities to perform the following in order to receive funding under Title 38 U.S. Code Chapter 20 to house or serve homeless veterans:

"(Submit) to the Secretary a certification that the building where the entity proposes to provide such housing or services is in compliance with codes relevant to operations and level of care provided, including the most current Life Safety Code and all applicable State and local housing codes, licensing requirements, fire and safety requirements, and any other requirements in the jurisdiction in which the project is located regarding the condition of the structure and the operation of the supportive housing or service center." [1]

In its testimony before this Subcommittee on April 16, 2012, the Department of Veterans Affairs correctly noted that this legislation would have a very broad application, affecting such programs as the Supportive Services for Veteran Families (SSVF) Program, "even when veterans are not cared for in these structures." [2]

NCHV appreciates that the present version of the "Safe Housing for Homeless Veterans Act," introduced by Rep. McKinley in May 2013, would no longer affect programs that do not necessarily involve housing for homeless veterans. However, we are concerned about this bill's potential impact on community- and faith-based organizations.

Need to Clarify Who Bears the Burden of Certification

The Department of Veterans Affairs is barred by law from making per diem payments under Title 38 U.S. Code § 2012 unless an organization has shown that its facilities "meet applicable fire and safety requirements under the Life Safety Code of the National Fire Protection Association or such other comparable fire and safety requirements as the Secretary may specify." [3] VA abides by this statute by conducting thorough inspections before making an initial per diem award to a service provider.

If this initial inspection is successful and per diem funding is awarded, VA will continue to monitor the facility in question as well as provide regular re-inspections to ensure that, among other things, it continues to meet the applicable fire and safety requirements.

H.R. 2065 introduces the concept of an "annual certification" that would require all per diem recipients to demonstrate the following:

"That the building where the entity provides such housing or services is in compliance with codes relevant to the operations and level of care provided, including applicable provisions of the most recently published version of the Life Safety Code or International Building Code and International Fire Code (or such versions of such codes that have been adopted as State or local codes by the jurisdiction in which the project is located), licensing requirements, fire and safety requirements, and any other requirements in the jurisdiction in which the project is located regarding the condition of the structure and the operation of the supportive housing or service center." [4]

NCHV is concerned that H.R. 2065 – as currently written – could discontinue VA's current practices, in which the department determines whether facilities are in Life Safety Code compliance during its regular re-inspections.

Do these current practices constitute "annual certification," as described in this bill? If so, H.R. 2065 should be amended to clarify that VA maintains responsibility

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[1] *http://thomas.loc.gov/cgi-bin/bdquery/z?d112:h.r.004079:*
[2] *http://veterans.house.gov/witness-testimony/robert-l-jesse-md-phd-0*
[3] *http://www.law.cornell.edu/uscode/text/38/2012*
[4] *http://www.gpo.gov/fdsys/pkg/BILLS–113hr2065ih/pdf/BILLS–113hr2065ih.pdf*

for conducting all such inspections and providing certification. If not, this bill could place a significant burden on service providers to orchestrate and pay for these rigorous inspections out-of-pocket. This issue must be addressed before NCHV could consider making an endorsement.

On the topic of whether or not International Building and Fire Codes should be used interchangeably with the Life Safety Code, as this bill would allow, NCHV defers to VA for its expertise in this area.

In Summation

While NCHV does not support H.R. 2065 at this time, we are hopeful that the appropriate changes can be made to ensure that veteran service providers are not adversely impacted by this legislation.

Thank you for the opportunity to submit this Statement for the Record. It is a privilege to work with the House Committee on Veterans' Affairs, Subcommittee on Health, to ensure that every veteran in crisis has reasonable access to the support services they have earned through their service to our country.

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NCHV Policy Director

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NCHV Disclosure of Federal Grants

Grantor: U.S. Department of Labor
Subagency: Veterans' Employment and Training Service
Grant/contract amount: $350,000
Performance period: 8/13/2012 - 8/12/2013
Indirect costs limitations or CAP limitations: 20% total award
Grant/contract award notice provided as part of proposal: Yes

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Indirect costs limitations or CAP limitations: 20% total award
Grant/contract award notice provided as part of proposal: Yes

PARALYZED VETERANS OF AMERICA

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) thanks you for the opportunity to submit a statement for the record regarding the five pieces of proposed legislation being considered today. PVA appreciates that you are addressing these important issues involving the health of our nation's veterans.

The "Long-Term Care Veterans Choice Act"

PVA generally supports the "Long-Term Care Veterans Choice Act." This bill proposes to amend title 38, United States Code to authorize the Department of Veterans Affairs (VA) to enter into contracts or agreements for the transfer of veterans to non-VA adult foster homes for certain veterans who are unable to live independently. PVA believes that VA's primary obligation involving long-term support services is to provide veterans with quality medical care in a healthy and safe environment.

As it relates to veterans with a catastrophic injury or disability, it is PVA's position that adult foster homes are only appropriate for disabled veterans who do not require regular monitoring by licensed providers, but rather have a catastrophic injury or disability and are able to sustain a high level of independence. When these veterans are transferred to adult foster homes, care coordination with VA specialized systems of care is vital to the veterans' overall health and well-being. The drafted text of this bill requires the veteran to receive VA home health services as a condition to be transferred. As such, PVA believes that if a veteran with a spinal cord injury or disorder is eligible and willing to be transferred to an adult foster home, the VA must have an established system in place that requires the VA home based primary care team to coordinate care with the VA SCI/D Center and the SCI/D primary care team that is within the closest proximity to the adult foster home. When caring for a veteran with a catastrophic injury or disability this specialized

expertise is extremely important to prevent and treat associated illnesses that can quickly manifest and jeopardize the health of the veteran.

When catastrophically injured or disabled veterans who receive services from one of the VA's specialized systems of care are placed in a non-VA adult foster home they must be regularly evaluated by specialized providers who are trained to meet the needs of their specific conditions. PVA also believes that as this draft legislation is aptly titled the, "Long Term Care Veterans Choice Act," veterans should only be transferred from a VA facility to a non-VA adult foster home with the full consent of the veteran, pursuant to title 38 U.S.C., Section 1710A(b)(1).

H.R. 1443, the "Tinnitus Research and Treatment Act"

PVA does not have a position on H.R. 1443, the "Tinnitus Research and Treatment Act of 2013," a bill that proposes to direct the VA to recognize tinnitus as a mandatory condition for research and treatment. PVA supports VA research efforts involving hearing loss and conditions such as tinnitus, however, we believe that the selection of research subject areas and projects should be done through the VA scientific peer review process.

H.R. 1612

PVA does not have a position on H.R. 1612, a bill to direct the VA to convey a parcel of land in Tuskegee, Alabama, to Tuskegee University.

H.R. 1702, the "Veterans Transportation Service Act"

PVA supports H.R. 1702, the "Veterans Transportation Service Act," a bill to amend title 38 United States Code to make permanent the authority of the VA to transport individuals to and from VA facilities when it is in connection with rehabilitation, counseling, examination treatment, and care. Too often lack of transportation is a barrier to veterans' access to medical care. This is frequently the case for disabled veterans who do not have a personal means of transportation. Arranging for accessible transportation can be very arduous and time consuming, and as a result it is common for disabled veterans who are not able to drive themselves to medical appointments to delay health care until transportation can be arranged, or forgo medical attention completely. It is for this reason that PVA strongly supports H.R. 1702 and encourages Congress and VA to further improve veterans' access to care by providing accessible transportation for disabled veterans, specifically veterans who have incurred a spinal cord injury or disorder, or veterans who use a wheelchair.

H.R. 2065, the "Safe Housing for Homeless Veterans Act"

PVA does not have a position on H.R. 2065, the "Safe Housing for Homeless Veterans Act." If enacted this legislation would amend title 38, United States Code, to require entities that provide services to homeless veterans and receive per diem payments from the VA to comply with codes relevant to operations and level of care provided to veterans. PVA supports Secretary Shinseki's goal of eradicating homelessness among America's veterans, and believes that the safety of facilities that offer services to homeless veterans is of extreme importance.

Paralyzed Veterans of America appreciates this opportunity to express our views on the proposed bills being reviewed. We look forward to working with the Subcommittee on these and other issues in the future, and are happy to answer any questions.

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

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

Fiscal Year 2013

No federal grants or contracts received.

Fiscal Year 2012

No federal grants or contracts received.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $262,787.

VIETNAM VETERANS of AMERICA

Chairman Benishek, Ranking Member Brownley, and distinguished members of the House Veterans' Affairs Subcommittee on Health, Vietnam Veterans of America (VVA) appreciates the opportunity to offer this Statement for the Record on pending legislation before this subcommittee.

Draft legislation: Long-Term Care Veterans Choice Act: Would authorize the Secretary of Veterans Affairs to enter into contracts for the transfer of certain veterans who are unable to live independently into non-Department adult foster homes.

This seems like a good idea on the face of it, but there just isn't enough detail for VVA to support this bill at this juncture. For example, what is the meaning of the phrase ". . . for certain veterans who are unable to live independently"?

Furthermore, the proposed legislation states that "At the request of a veteran for whom the Secretary is required to provide nursing home care under 1710A of this title, the Secretary may transfer the veteran to an adult foster home that meets Department standards at the expense of the United States . . . " Who will decide which type of facility (and where) the veteran can choose to be transferred to? Currently there is a variety of facility options currently recognized by the VA, such as an adult family home, an assisted living facility, a community nursing home, a medical foster home, a state veterans home, or a community living center, and each of these options has separate eligibility criteria, including the veteran's income level.

This proposed draft legislation needs far more detail before VVA can give further consideration of support. The issue, though, is of high import to us, inasmuch as Vietnam-era veterans now constitute the largest living cohort of elderly American veterans.

H.R.1443: Tinnitus Research and Treatment Act of 2013; introduced by Congressman Michael Michaud (ME–2): would direct the Secretary of Veterans Affairs to: 1) recognize tinnitus as a mandatory condition for research and treatment by Department of Veterans Affairs Auditory Centers of Excellence; 2) ensure that research is conducted at VA facilities on the prevention and treatment of tinnitus; and 3) ensure VA cooperation with the Hearing Center of Excellence established by the Department of Defense (DoD) to further research on tinnitus. **VVA supports H.R. 1443.**

H.R.1612: To direct the Secretary of Veterans Affairs to convey a specified parcel real property at 2400 Hospital Road in Tuskegee, Alabama, to Tuskegee University, for the purpose of permitting the university to use the property to further the educational and general welfare of its students; **introduced by Congressman Mike Rogers, (AL–3).**

The Tuskegee Airmen were the most highly respected African American troops of World War II, the University of Alabama donated 300 acres of land to build a hospital solely to care for black veterans in the South and today that hospital is the Tuskegee Veterans Affairs Medical Center. In February 2013 the Tuskegee VAMC celebrated 90 years of service to veterans and their families. In honor of the Tuskegee Airmen's service and sacrifice to our nation, **VVA supports H.R. 1612.**

H.R.1702: Veterans Transportation Service Act; introduced by Congressman Ron Barber (AZ–2); makes permanent (under current law, expires on January 10, 2014) the authority of the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with vocational rehabilitation, counseling, examination, treatment, or care. **VVA supports making this provision of the law permanent.**

H.R.2065: Safe Housing for Homeless Veterans Act; introduced by Congressman David McKinley (WV–1); would require recipients of per diem payments for the provision of services for homeless veterans to comply with codes relevant to operations and level of care provided.

The VA Homeless Providers Grant and Per Diem Program provides grants and per diem payment assisting public and nonprofit organizations in establishing and operating supportive housing and service centers for homeless veterans. When enacted into law, H.R 2065 would mandate that these public and nonprofits organizations are in compliance with Life Safety Code of the National Fire Protection Association and other requirements as stated in Section 61.20 Life Safety Code Capital

Grants in the VA Homeless Providers Grant and Per Diem Program regulations. **VVA applauds Congressman McKinley for introducing this legislation and supports H.R. 2065 as written.**

Mr. Chairman and members of the House Veterans Affairs Subcommittee on Health VVA would like to thank you for the opportunity to submit our Statement for the Record on legislation that would improve the quality of life for veterans and their families before this subcommittee today.

VIETNAM VETERANS OF AMERICA

Funding Statement

July 9, 2013

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives).

This is also true of the previous two fiscal years.

For Further Information, Contact:

Executive Director of Policy and Government Affairs

Vietnam Veterans of America.

(301) 585–4000, extension 127

WOUNDED WARRIOR PROJECT

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to provide views on pending health-related legislation. We welcome this opportunity to address two of the measures before you.

LONG TERM CARE VETERANS CHOICE ACT

A draft bill under consideration is apparently intended to authorize VA to contract for room, board, and caregiver services in adult foster homes for veterans for whom VA would have an obligation to provide needed nursing home care. The measure would also provide for a participating veteran to receive VA home health services.

Wounded Warrior Project welcomes the proposal to add medical foster home care to the continuum of long-term care options for wounded warriors. Almost without exception, our work with wounded warriors and their families has underscored how important it is to enable the individual to live in the community and avoid institutionalization. The comprehensive caregiver assistance program established in Public Law 111–163 has proven enormously helpful in realizing that goal for those who were seriously injured on or after 9/11 and need personal care services. But we do encounter parents and other family members who worry about a time when they might no longer be able to sustain caregiving, as well as seriously injured warriors who have no family to provide care. Given wide-ranging needs and preferences among those who cannot live independently,[1] there is merit to fostering new ap-

[1] A 2012 report on deinstitutionalized disabled individuals by the National Council on Disability cited studies based on the National Core Indicators 2009–10 Survey to assess their preferences for housing, dividing responses into independent living, living with family members, living in a community-based setting (such as a small group home or foster care with a host family) or living in an institution (nursing home or large group home). Overall, ninety percent responded that they liked where they lived, but those surveyed expressed the most satisfaction with living with family members (96%) and the least with institutional settings (83%). Those in individual homes (90%) and in community based settings (87%) were in the middle. When asked if they would like to live somewhere else findings were somewhat consistent. Only 20% of those living with parents expressed a desire to live elsewhere compared with 39% of institutionalized respondents. Twenty-six percent of those in individual homes and 30% of those in community settings responded positively. Human Services Research Institute/ National Association of State Directors of Developmental Disabilities Services, National Core Indicators, 2011 as

proaches. In sum, we applaud the effort to develop a statutory framework to enable VA to provide a community-based, home-like alternative to institutional care that includes needed home-health services.

The legislation would vest the Department with broad authority to set standards for these homes. It is our understanding that adult medical foster homes are generally subject to state licensing requirements. But the draft bill sets no express expectations of VA with regard to those standards, which in our view should not simply default to a state licensure requirement, given the very vulnerable individuals covered under the draft bill. We do understand that VA has worked for some time with foster-home care providers under arrangements where the veteran has borne the costs of that care. It seems likely that the number of veterans who might choose a foster home option would grow were such legislation enacted. That scenario does raise questions as to how the program would operate, and what kind of oversight would be provided. What kind of training would caregivers receive? What precautions would be taken to ensure placements were clinically and age appropriate for the veteran? How would VA ensure that medical foster homes have appropriate oversight and that veterans and their families are satisfied with the services they receive there? We would encourage the Subcommittee to press VA to address those questions early on and clearly define expectations regarding standards of care, as well as outline how they would evaluate a potential residence's ability to provide for younger generations of veterans who have unique rehabilitative needs.

Finally, while we welcome this initiative, we would be remiss if we failed to note that VA still has important work to do as it relates to the long term rehabilitative care for those with moderate to severe traumatic brain injury, and particularly with implementation of section 107 of Public Law 112–154. Those provisions of law require that rehabilitative care for traumatic brain injury focus not only on achieving functional gains but on sustaining them, and that veterans be afforded community-based rehabilitative services or supports that contribute to maximizing an individual's independence. While Wounded Warrior Project, through our Independence Program, is working every day to help warriors with severe traumatic brain injury reach their fullest potential in their communities, we have not seen VA take comparable steps to implement a now year-old law requiring such action.

Without ongoing rehabilitative care and community supports that Congress directed VA to provide, many post 9/11 Warriors with severe brain trauma will be relegated to lives of greater dependency, and without the social networks or employment options their non-disabled peers take for granted. VA must make significant improvements to ensure an adequate rehabilitative services continuum is available before placement of younger gravely injured veterans in residential settings other than their own or family homes will be acceptable.

TINNITUS RESEARCH AND TREATMENT ACT OF 2013

H.R. 1443 would direct VA to recognize tinnitus as a mandatory condition for research and treatment by VA Auditory Centers of Excellence and for that research to include the study of treatments, etiology, and underlying mechanisms of the disorder. The bill also directs VA to work with the Department of Defense's Hearing Center of Excellence to advance research on tinnitus.

With 52% of Wounded Warrior Project Alumni reporting tinnitus and 17% experiencing severe hearing loss, we welcome the focus on exploring improved prevention and treatment of hearing disorders.[2] As a very common health problem with limited treatment options, advancing research in this area could have a significant impact in improving care for wounded veterans. We see particular value in fostering the study and evaluation of prevention, assessment, and treatment of tinnitus through collaboration between the VA and the Department of Defense since it is strongly associated with service and exposure to a combat zone.[3] Advancements in preventing hearing loss and tinnitus will have to happen within the military, so it is important to ensure gains in knowledge and understanding are translated into improvements on the battlefield and in training.

We are supportive of continuing research and improvements in the treatment of tinnitus, as well as other forms of hearing loss. Tinnitus is an often very disabling problem that affects many warriors frustrated by the fact that there are as yet no effective treatments. We urge that continuing research also explore the varying im-

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cited in Deinstitutionalization Toolkit: Community in Detail, National Council on Disability, 2012, Figures 2–6.

[2] 2013 Wounded Warrior Project Survey Results

[3] Tzounopoulos, T. 2013. Mechanisms underlying Noise- Induced Tinnitus. Retrieved from http://cdmrp.army.mil/prmrp/research—highlights/2013.shtml

pact tinnitus can have on different people. As a chronic condition, the level of disability can differ significantly and improved understanding could better describe the spectrum of the condition and contribute to scientific and medical knowledge, as well as better prevention and care in the future and increased accuracy in disability ratings. Tinnitus merits robust research efforts and WWP would support legislation to advance understanding in this area.

Thank you for your consideration of WWP's views on these issues.

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