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STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 9, 2013

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,

[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).

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.

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.

[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.

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.

[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.
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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.

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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.